

# 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.

|  |  |                                     |
|--|--|-------------------------------------|
| <b>CIRT ID: 0TOU6ULKGF</b>   |  |                                     |
| <b>Date of critical incident:</b><br>March 16, 2020                          | <b>Date Department became aware of the fatality:</b><br>March 16, 2020                             |                                     |
| <b>Date Department caused an investigation to be made:</b><br>March 16, 2020 | <b>Date of Office of Training, Investigations and Safety investigation disposition:</b><br>PENDING |                                     |
| <b>Date CIRT assigned:</b><br>March 20, 2020                                 | <b>Date Final Report submitted:</b><br>June 26, 2020   |                                     |
| <b>Date of CIRT meetings:</b><br>5.4.20                                      | <b>Number of participants:</b><br>11   | <b>Members of the public?</b><br>No |

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

| <b>Date of report:</b>                                   | <b>Allegation(s):</b>                                     | <b>Disposition(s):</b> |
|--|---|------------------------|
| March 16, 2020   | Neglect of Child in Care by unidentified program employee | Pending                |
| <b>Assignment decision:</b><br>Assigned – within 10 days |   |                        |

On March 16, 2020, the Office of Training Investigations and Safety (OTIS), a program under the umbrella of the Department of Human Services, received a report via the Oregon Child Abuse Hotline alleging neglect of the child. The child was eighteen years old but met the statutory definition of a child due to living in a Child Caring Agency (CCA) at the time of the critical incident. According to the report the child was found unresponsive around 12 a.m. The child had been living semi-independently at the CCA. The reporter noted routine checks had been completed throughout the prior evening and the child had been observed sleeping before being found unresponsive by a roommate. Emergency response was contacted, and life-saving efforts were performed prior to transporting the child to the hospital. The child died later the same day. It was believed the child died from an overdose of oxycodone.

Additional detail in the report noted the child had complained to other residents of not feeling well over the previous week, however the child had not talked with program staff and no medication had been administered to the child. The child had some history of alcohol and marijuana use. There was no other information about what substances may have been consumed or where they came from.

Investigation by OTIS did not reveal any negligence by program staff. The youth in the program live quite independently and the child in this case had been doing well. Review of incident reports and video show several staff members performing supervision checks in the room where the child slept. Based on program documentation, policies and staff interviews, the checks appeared to be consistent with the program's requirements for supervision. The final disposition related to the allegation of neglect is pending as the law enforcement investigation is not yet complete.

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### Description of relevant prior Department reports:

| <b>Date of report:</b>      | <b>Allegation(s):</b>                  | <b>Disposition(s):</b> |
|-----------------------------|--|------------------------|
| March 26, 2019              | Physical Abuse by unknown perpetrators | N/A                    |
| <b>Assignment decision:</b> |  |                        |
| Closed at Screening         |  |                        |

On March 26, 2019 the Department received a report regarding a physical assault that occurred while the child, age 17, was visiting their family home. The perpetrators were reported to be three unknown adult men. The child was treated for cuts and abrasions to the head and returned to their placement outside the family home.

The report was closed at screening as it was a report of third party abuse by unknown, unrelated perpetrators and the child would not be returning to the family home until the law enforcement investigation was complete.

| <b>Date of report:</b>      | <b>Allegation(s):</b>                          | <b>Disposition(s):</b> |
|-----------------------------|--|------------------------|
| October 17, 2019            | Neglect by unidentified program staff in a CCA | N/A                    |
| <b>Assignment decision:</b> |  |                        |
| Closed at Screening         |  |                        |

On October 17, 2019 the Department received a report with information the child, age 17, and another resident snuck out of their proctor foster home late at night and stole a vehicle in the community. The youth ran from police and crashed the car, though no one was injured. The report was closed at screening as there was no information to suggest the incident was a result of inadequate supervision by the foster parents.

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### **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 any concerns regarding actions taken or not taken in response to the critical incident or events leading to the critical incident. The child had only been the subject of two prior reports, both of which had been closed at screening. The program in this case offers significant independence to residents who are over eighteen years of age and does not provide services to youth involved with Child Welfare. The child was reported to be doing well in the CCA and there was no indication neglect occurred.

### **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:**

The CIRT did not have any recommendations for improvement in the administration and oversight of the child welfare system related to this case.