

J.K CIRT Public Report

Date	November 1, 2018
Purpose of Final Report	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.
Date of Initial Report	February 12 th , 2018
Executive Summary	The Department received a total of four reports of abuse between 2007 and 2017 prior to J.K.'s death. Of those reports, none were founded for abuse. The report received prior to J.K.'s death was specific to his suicidal ideation and closed believing the family was providing adequate care and supervision of J.K. Five months later, the Department was notified that J.K. died by suicide.
Summary of Critical Incident	On April 24, 2017, the Department was notified that on April 22, 2017, J.K. died by suicide because of a self-inflicted gunshot wound. J.K. had been given a firearm one month prior as a birthday present. Firearms had recently been removed from the property because of J.K.'s suicidal ideation. However, weapons were brought back into the home without consulting J.K.'s counselors. Additionally, J.K.'s parents had recently separated causing additional family stress. On the day of the incident, J.K. was left unsupervised at the home for a period of 15-30 minutes during which time he had access to unsecured firearms and ammunition. J.K. accessed the gun and died

	<p>by suicide. The Department founded this report for neglect of J.K by his parents.</p>
<p>Evaluation of actions taken by The Department</p>	<ul style="list-style-type: none"> • Medical and hospital records were not requested or reviewed until after the death of J.K. These records, however, contained critical information regarding previous threats to use firearms to attempt suicide. The records would have provided information specific to child vulnerability and provided insight in determining if the parents were able to fully meet the child's needs. • Child welfare staff lack training required to help families coordinate an adequate response to children at risk of suicide. • This report met criteria to be assigned as a traditional response CPS assessment based on J.K.'s previous suicidal ideation and the history and pattern of violence in the family home.
<p>Recommendations for improvements and associated tasks</p>	<ul style="list-style-type: none"> • Convene a workgroup to evaluate data related to youth suicide in Oregon and research practical approaches to education of child welfare staff. <ul style="list-style-type: none"> ○ The workgroup began in December of 2017 and consisted of Department staff and representatives from the Oregon Health Authority Children's Mental Health Division. Statewide youth suicide data was evaluated, and it was determined the Department has a role to play in the public health effort to prevent youth suicide. The workgroup then began researching approaches to suicide intervention and prevention. • Select a simple tool to assist child welfare staff in assessing cases involving risk of youth suicide. <ul style="list-style-type: none"> ○ The workgroup chair conducted research along with OHA partners and identified a suicide prevention method to be utilized in child welfare. QPR (Question, Persuade, Refer), an evidence-based suicide prevention approach, was selected in June of 2018. Child Safety Program Coordinators were identified to become certified trainers. A plan was developed to bring QPR to select child welfare staff by fall of 2018. • Develop and deliver training for child welfare staff on youth suicide, including how to recognize risk and protective factors.

	<ul style="list-style-type: none"> ○ Training for Child Welfare supervisors and consultants on QPR occurred in September and October 2018 by Child Safety Program Coordinators. Planning is underway for training of remaining field staff, to include selecting individuals to be identified as trainers in local field offices. This is expected to occur by spring of 2019. ● Encourage local multi-disciplinary teams to review cases involving youth suicide. <ul style="list-style-type: none"> ○ The Child Safety Program Coordinator assigned to this work contacted each of the multi-disciplinary teams in Oregon during the summer of 2018. Local protocols will be updated to incorporate cases involving youth at risk of suicide into the staffing and review structure. This is expected to be completed in 2019.
<p>Methods of evaluating expected outcomes</p>	<p>Outcomes will be measured through review and comparison of state fatality rates related to suicide to determine if training and efforts of education carry impact.</p>