

S.S. CRITICAL INCIDENT RESPONSE TEAM FINAL REPORT FOR PUBLICATION

November 1, 2018

Purpose of Critical Incident Response Team Reports:

Critical Incident Response Team (CIRT) Reports are used as tools to improve child welfare practice when the Oregon Department of Human Services (DHS) 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. CIRTs are convened by the DHS Director to quickly analyze Department 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 or program areas 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 final reports are posted on the Department website.

The Department is committed to evaluating its processes and learning how the child welfare system may be improved in order to keep Oregon's children safer. The Critical Incident Response Team's efforts to identify issues are an important component of agency accountability and improvement when tragedies like this occur. In addition to the CIRT, but in a separate process, the Department may address any necessary personnel actions.

Executive Summary:

On September 8, 2017, the Oregon Department of Human Services (DHS) was notified that a child, S.S., was found in the family home after attempting suicide by hanging on September 5, 2017. The child was transported to the hospital and died on September 7, 2017. At the time of the fatality, it was reported the mother had failed to provide S.S. with appropriate supervision by leaving the child unattended despite knowledge that S.S. was suffering from a mental health crisis. A Child Protective Services (CPS) assessment had been open since July 11, 2017 in response to an earlier report received regarding S.S.

On September 29, 2017, DHS Director Fariborz Pakseresht declared a Critical Incident Response Team (CIRT) be convened to examine the Department's practice and service delivery to S.S. and the child's family. Because the death of S.S. appeared likely the result of abuse, a CIRT was mandatory pursuant to Oregon Revised Statute 419B.024.

On October 5, 2017, the initial CIRT meeting was held and a comprehensive case file review was initiated. On November 3, 2017, the CIRT met a second time to discuss the

case file review in order to assist in identifying systemic issues that may have given rise to the incident.

The initial report of the CIRT was submitted to the Department on December 21, 2017. Although the disposition in the case was ultimately unfounded in March of 2018, the Department elected to proceed with the CIRT report to describe the original recommendations and to implement positive changes resulting from work which had already begun. The final report of the CIRT was delayed due to recent statutory revisions affecting department process as well as a change in the CIRT Coordinator position.

Summary of Critical Incident:

The Department has been contacted three times regarding S.S.'s family, including notification of the fatality. Each of these reports was assigned for Child Protective Services (CPS) assessments.

On November 17, 2014, the Department received the first report regarding S.S.'s family. The report alleged physical abuse and mental injury of S.S. by the mother after the child disclosed an incident that occurred a few days prior. This report was assigned for assessment. The child had no injuries, however reported having injuries in the past. The assessment concluded with an unfounded disposition for physical abuse and an unable to determine disposition regarding mental injury. The family was referred for a Family Strengths and Needs Assessment, indicating a determination of Moderate to High Needs, yet the mother declined to participate in the optional service.

On July 11, 2017, the Department received a report regarding concerns of physical abuse of S.S. According to the report, on July 8, 2017, S.S. intentionally overdosed and was admitted for evaluation. During this time, S.S. disclosed physical abuse by the father. The report was assigned for alternative response assessment. The assessment was open when the Department received notification of S.S.'s death and had not been completed upon review by the CIRT. However, the allegation of physical abuse of S.S. was ultimately unfounded against the father.

On September 8, 2017, the Department received a report indicating that on September 5, 2017, S.S. had attempted suicide by hanging, while the mother was at work. S.S.'s sibling found S.S. and sought assistance from a neighbor in calling emergency responders. S.S. was transported to the hospital and died on September 7, 2017. The mother had left S.S. and the sibling home alone, despite receiving instruction from medical professionals to provide line of sight supervision until S.S. was actively engaged in therapy and had stabilized.

The assessment ultimately resulted in an unfounded disposition in March 2018 after all facts and circumstances were reviewed by the Department.

Status of Case Review:

The CIRT has completed the review of the S.S. case.

Conclusions:

The CIRT did not identify any practice errors that directly correlated with the fatality. However, the team identified some areas of concern and missed opportunities for improved practice and increased child safety.

The 2014 assessment was somewhat brief and limited in scope. While the assessment provided relevant information about each family member, gathering additional information may have assisted the caseworker in gaining a better understanding of family functioning and in making a safety determination. The mother was born abroad and while the caseworker noted a conflict between the mother's experience and desire to parent in the traditions of her culture and the expectations around parenting and discipline in the United States, the caseworker does not reconcile the incongruence. Also, while the mother spoke limited English, there was no indication a translator was sought out or offered.

Although the July 2017 report was pending at the time of the fatality, the CIRT noted that the assessment was incident based and lacked comprehensiveness. The caseworker made contact with the mother and children and interviewed the children separately. S.S. denied injury, a pattern of abuse and denied current suicidal ideation. The caseworker noted the mother struggled with some concepts of American culture around parenting and discipline. The caseworker also thought the mother's lack of understanding of S.S.'s mental health could have a cultural component. However, cultural dynamics were not fully explored and there is no documentation that a translator was offered. The mother reported the family was following up on S.S.'s mental health treatment needs, and an appointment was scheduled for the child, yet verification of efforts did not occur. The CIRT believed there were missed opportunities to gather information from collateral contacts to confirm S.S.'s treatment needs and the family's ability to follow through on recommendations.

Recommendations & Process Improvements:

1. IDENTIFY STATEWIDE AND LOCAL RESOURCES TO ASSIST CHILD WELFARE STAFF IN ASSESSING AND ENGAGING FAMILIES FROM NON-DOMINANT CULTURES, UNDERSTANDING CULTURAL DYNAMICS, AND PROVIDING CULTURALLY APPROPRIATE SERVICES.

While not identified as a statewide systemic issue, the CIRT expressed concern over equitable access to services and the lack of resources available for child welfare staff in serving Limited English Proficiency (LEP) and Non-English Proficiency (NEP) individuals and families. In addition to in person interpretation services and translation of written materials, the Office of Equity and Multicultural Services (OEMS) has contracted to provide on-demand access to video and telephone interpretation services. This service adds video based American Sign Language interpretation; offers a range of spoken languages including those not offered by other contracted services; is available 24/7 and on demand. OEMS will continue to develop and implement strategies to close gaps in service outcomes and develop metrics that measure and demonstrate successful outcomes. Additionally, the Department requires staff to participate in Cultural Competency and Cultural Humility training and offers additional training for staff including Cross-Cultural Communications and cultural sensitivity.

Tasks & Implementation:

- There are no ongoing tasks associated with this recommendation as statewide work has been underway for some time and resources are available. The local offices in this case were provided information about how to access existing resources for future cases at the time of the review.

2. PROVIDE CHILD WELFARE STAFF WITH TOOLS AND TRAINING TO ASSIST IN CASES INVOLVING RISK OF YOUTH SUICIDE.

The CIRT discussed the limitations surrounding training for caseworkers in thoroughly assessing suicidal ideation in youth, as well as the lack of resources and tools available to staff in this area.

Tasks & Implementation:

- Convene a workgroup to evaluate data related to youth suicide in Oregon and research practical approaches to education of child welfare staff.
 - 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.

- 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.
 - 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.
 - 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.

Methods of Evaluating Expected Outcomes:

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.