

# CRITICAL INCIDENT RESPONSE TEAM FINAL REPORT T.D.

October 2, 2018

## Purpose of Critical Incident Response Team Reports:<sup>i</sup>

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 20, 2017, the Oregon Department of Human Services (DHS) was notified that a child, T.D.,<sup>1</sup> was found deceased in the family home after completing suicide by hanging on September 18, 2017. A Child Protective Services (CPS) assessment had been open since July 13, 2017 in response to a report received regarding T.D.

On October 5, 2017, DHS Director Fariborz Pakseresht declared a Critical Incident Response Team (CIRT) be convened to examine the Department's practice and service delivery to T.D. and the child's family. This is a mandatory CIRT, pursuant to Oregon Revised Statute 419B.024.<sup>2</sup>

On October 13, 2017, the initial CIRT meeting was held and a comprehensive case file review was initiated. On November 7, 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. At that time, areas of concern were noted regarding the Department's practice and service delivery on this case.

The initial report of the CIRT was submitted to the Department on January 29, 2018. This is the final report of the CIRT.

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<sup>1</sup> The child will be referred to by the child's initials in order to maintain confidentiality for the child and the child's family.

<sup>2</sup> Oregon Revised Statute 419B.024 can be retrieved at <http://www.oregonlaws.org/ors/419B.024>

### **Summary of Critical Incident:**

On September 20, 2017, the Department was notified that T.D. had completed suicide by hanging in the family home on September 18, 2017. The report alleged neither parent believed the child's disclosure; additional concerns were reported regarding the treatment of T.D. by the child's parents. This report was assigned for assessment, linked to the earlier report, opened on July 13, 2017, and both reports were assessed together. The assessment had not yet concluded at the time the CIRT was declared, but has since been completed, resulting in a disposition of founded for neglect.

### **Status of Case Review:**

The case review is complete.

### **Conclusions:**

The CIRT found decisions and actions taken by the Department may have had some impact on the outcome of this case. In situations where adolescents are experiencing mental health symptoms, have expressed suicidal ideation and/or have attempted suicide, it is important for the Department to involve professionals in understanding the risk factors present and to safety plan accordingly. Over the course of the CPS assessment, the caseworker should gain a comprehensive understanding of the protective capacities of the adults providing daily care of a child in order to attempt to prevent the outcome of suicide.

For the purposes of this review, the CIRT focused on the assessment activities prior to the fatality. The review noted many strengths in the pending assessment, in particular the documentation on this case was thorough, descriptive and captured the complexity of the safety issues present for this child. Further, the review noted that the caseworker made appropriate collateral contacts and gathered safety related information throughout the assessment. However, the CIRT also noted areas that were not consistent with Oregon Administrative Rules (OARs). For instance, the caseworker met with the parents on the same day as receiving the assessment, but face to face contact with the child was not made until approximately one week later. Additionally, there was no documentation of contact with the alleged perpetrator from the July report.

The case review disagreed with the decision made by the branch to not initiate a protective action plan following the child's evaluation on July 25, 2017 at the local Child Abuse Intervention Center (CAIC). Protective actions are required when a child is assessed and determined to be in present danger. During this evaluation, T.D. made a clear disclosure of abuse and presented as extremely emotional because the parents did not believe the disclosure. Following the evaluation, CAIC staff discussed the disclosure with the parents. Documentation indicates the parents reacted in a severely negative manner. They were visibly angry and threatened legal action against the child. CAIC staff advised against the child returning home with the parents given their reactions. The caseworker attempted to engage the family in safety planning for T.D., however all options were exhausted and they were unable to identify family members or friends where T.D. could stay. The possibility of placing T.D. in foster care was considered but never came to fruition as the parents were opposed to this option. The CIRT noted that the Department must make the decision of removal regardless of the parents' opposition as it is a child safety decision. The parents requested to meet with the program manager and this meeting occurred later that day with the caseworker and supervisor also in attendance. Prior to leaving the CAIC, T.D. denied current suicidal ideation and expressed a

desire to go home. The caseworker believed T.D would be safe and allowed the child to return home with the parents.

At the meeting later that day, a plan was made for T.D. to remain in the home with the parents who agreed to continue the child in therapy, seek further evaluation of T.D's treatment needs and allow the caseworker to continue to meet with the child throughout the assessment. The parents' willingness to comply with the agreement was factored into the decision to leave T.D. in the home. Based on the information available, the CIRT determined that it would have been more appropriate for the branch to have pursued legal intervention due to the extreme nature of the parents' disbelief and treatment of the child. However, at a minimum, the CIRT concluded that a sufficient safety plan should have been implemented. It is unclear if this decision ultimately impacted the outcome for T.D. but it is an area of concern noted by the CIRT. The caseworker met with T.D. the following day and documented the child reported "doing fine" and "felt fine at home." The caseworker met with T.D. again on August 8, 2017, and the youth reported an improved relationship with the mother however became emotional and expressed a continued desire for the parents to believe the disclosure of abuse. Additional contacts were made with the child, providers and family members prior to the fatality.

While the concerns surrounding practice were specific to this case, the CIRT felt these concerns should be emphasized to staff statewide, including correct application of the safety threshold criteria in determining safety threats, correct application of the in-home criteria and how to sufficiently manage child safety when present or impending danger exists. This led to a discussion about the need for caseworkers to receive regular, intentional supervision related to safety decision making consistent with the practice model. This level of supervision would provide assistance with case planning and monitoring as well as ongoing support in an effort to reduce secondary trauma and increase staff retention. Currently, 44% of Oregon's child protective services staff have been with the Department for less than 18 months. The caseworker on this case had only been with the Department for a few months. In general, new caseworkers require close supervision while they are developing the skills necessary to assess the complicated dynamics present in many families who come into contact with child welfare. The frequency of this regular, intentional supervision should be determined by the level of experience and competence specific to each individual worker.

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. A recent CIRT with similar dynamics resulted in the formation of a workgroup comprised of Department staff, representatives from Oregon Health Authority Children's Mental Health, Oregon Public Health Division and representatives from other outside agencies with expertise on youth suicide prevention. The workgroup has initiated a data review of Oregon youth who have completed suicide and have prior child welfare history to inform the development of tools designed to assist staff in working with these families. The group will identify key risk and protective factors for child welfare families; select or develop a screening tool for Department staff and foster families working with and caring for youth; a resource guide of intervention and referral services; and training for Department staff and foster parents.

It is not the purpose of Critical Incident Response Teams to identify errors or inconsistencies in decision-making and/or practice of external agencies as most CIRT members are not experts in policy of partnering agencies and are therefore not qualified to come to such conclusions. In this particular case, as noted in the July report, there was an alleged crime involving historical abuse of

T.D. by a relative. The CPS assessment highlights the difficulties faced by the caseworker in locating the appropriate law enforcement jurisdiction. The caseworker contacted several different police jurisdictions which declined investigation of the alleged crime due to uncertainties as to specific location where the incident occurred. While the caseworker was eventually able to identify the appropriate law enforcement agency, the process was cumbersome and may have detracted from assessing T.D.'s immediate safety. Because the case worker had relatively little experience in child welfare, the law enforcement investigation may have taken on a higher level of importance that distracted from the immediacy of T.D.'s safety. This again highlights the importance of regular, intentional supervision for child welfare staff to ensure child safety is always at the forefront of any CPS assessment.

T.D. had expressed the negative impact of making a disclosure of abuse and not being believed by the parents. When law enforcement is actively involved in a case, they are often able to provide additional explanation to the family which may have lessened the discord within the family and may have served in supporting T.D. and validating the child's feelings. It is unclear if this dynamic played a role in the outcome of this case, and while the CIRT is aware of the difficulties involved in identifying the jurisdiction where the alleged crime may have occurred, the team felt compelled to note a concern about this area and opine as how this too may have impacted the child.

### **Recommendations & Process Improvements:**

1. TRAINING AND SUPPORT FOR SUPERVISORS IN PROVIDING REGULAR, INTENTIONAL SUPERVISION FOR STAFF, WITH FREQUENCY DEPENDENT UPON EACH INDIVIDUAL WORKER'S LEVEL OF EXPERIENCE AND COMPETENCE IN OPERATING WITHIN OREGON'S CHILD WELFARE PRACTICE MODEL.

This CIRT discussed the need for caseworkers to receive regular, intentional supervision related to safety decision making consistent with the practice model. This level of supervision would assist with case planning and monitoring as well as ongoing support, which aims to reduce secondary trauma and increase staff retention. With the influx of new caseworkers entering the CPS field, regular coaching to the practice model as well as close supervision for caseworkers is vital in the development of skills needed to ensure child safety. Supervisors must be adequately trained to provide this level of supervision to staff.

### **Tasks & Deliverables:**

- Develop training specifically designed to prepare child welfare supervisors to provide quality supervision of staff that encompasses not only daily workload management but also clinical aspects of the work, such as casework practice, dealing with vicarious trauma and burnout.
- Require supervisors to provide caseworkers with regularly scheduled, intentional supervision commensurate with the worker's level of experience and competence, to ensure adequate safety decision making and adherence to the practice model, and to reduce trauma and support retention.

The Child Welfare Training Services Unit has developed two Training Specialist positions dedicated to supervisor training and support. These positions have two priority goals:

Goal 1: Work with supervisors statewide to create a clinical supervision definition to provide a framework for supervisors new to this role as well as seasoned supervisors. A draft of the definition is under review by the Child Welfare Director.

Goal 2: Regular communication and support for supervisors in providing clinical supervision to staff. This is being accomplished through:

- Development and design of multiple supervision tools and communications in all areas of Child Welfare supervision
- Monthly Supervisor Newsletter with TIPS & Strategies for clinical supervision, which began in summer 2018
- Beginning the design of a dedicated supervisor web page that will have clinical supervision tools
- Purchase Supervision Cards for every supervisor statewide and provide regular guidance and practice opportunities for supervisors to learn how to use the cards. The cards provide flexibility to tailor supervision to an employee's individual needs and can be adapted to the unique context of a program, dilemma, or a goal agreed upon in supervision. The Training Services Unit will provide ongoing coaching, support, and ideas on how to use the supervision cards.

In addition, the Child Welfare Director has provided direction to supervisors to schedule weekly supervision with caseworkers.

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

The CIRT noted 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. As a result of a recent, similar CIRT, a workgroup was formed, comprised of Department staff, representatives from Oregon Health Authority Children's Mental Health, Oregon Public Health Division and representatives from other outside agencies with expertise on youth suicide prevention. The workgroup has initiated a data review of Oregon youth who have completed suicide and have prior child welfare history to inform the development of tools designed to assist staff in working with these families. The group will identify key risk and protective factors for child welfare families; select or develop a screening tool for Department staff and foster families working with and caring for youth; a resource guide of intervention and referral services; and training for Department staff and foster parents.

### Tasks & Deliverables:

- Develop simple tools to assist child welfare staff in assessing cases involving risk of youth suicide. Update policy and procedure, as necessary.
- Develop and deliver training for child welfare staff on youth suicide, including how to recognize risk and protective factors that contribute to suicidality and how to better serve families when a

youth has expressed the desire to or has attempted suicide. This training should provide child welfare caseworkers with an understanding of how to work with mental health providers and schools in safety planning and assessing risk.

- Encourage local multi-disciplinary teams to review cases involving youth suicide.

This workgroup has met regularly and have begun to identify tools and training to support staff in this area.

The Office of Child Welfare Programs is developing an implementation plan related to addressing youth at risk of suicide. Training will be provided first to supervisors by Child Safety Program and subsequently to remaining field staff.

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.

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<sup>i</sup> Given its limited purpose, a Critical Incident Response Team (CIRT) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of the child. The CIRT review is generally limited to documents in the possession of or obtained by the Department. The CIRT is not intended to be an information gathering inquiry and does not include interviews of the child's parents and relatives, or of other individuals associated with the child. A CIRT is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of the child fatality.