

# 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. Versions of all final reports are posted on DHS’ website.

<b>CIRT ID: TLWZ8NL2YG</b>		
<b>Date of critical incident:</b> December 1, 2019	<b>Date Department became aware of the fatality:</b> December 4, 2019	
<b>Date Department caused and investigation to be made:</b> December 4, 2019	<b>Date of child protective services (CPS) assessment disposition:</b> February 6, 2020	
<b>Date CIRT assigned:</b> December 5, 2019	<b>Date Final Report submitted:</b> March 13, 2020	
<b>Date of CIRT meetings:</b> December 27, 2019 February 5, 2020	<b>Number of participants:</b> 12 22	<b>Members of the public?</b> No Yes

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

<b>Date of report:</b> 12.2.19 & 12.4.19	<b>Allegation(s):</b> Neglect by Child Caring Agency employee	<b>Disposition:</b> Substantiated
<b>Assignment decision:</b> Within 10 business days		

On December 2, 2019, 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 nineteen years old but met the statutory definition of a child due to living in or receiving services from a Child Caring Agency (CCA). According to the report, the child left a CCA on December 1, 2019 after being under an enhanced level of supervision since November 30, 2019 due to concerns of suicidal behavior. The report alleged a staff member allowed the child to leave the program, which was against the protocol developed for when children in the program are a risk to themselves.

On December 4, 2019, OTIS received an additional report after the child died by suicide.

Both reports were assigned to the same investigator. Several staff members from the CCA and two children in the program were interviewed. Various records were gathered and reviewed, including assessments and evaluations of the child as well as protocols and staff training information. It was determined the child had a history of suicidal ideation and several prior suicide attempts. The program was aware of the child's history and the child's plan addressed these concerns.

In the days prior to the fatality, the child had gotten into an altercation with another resident of the program. Shortly after, program staff found the child braiding shoelaces and looping them in a manner that caused concern. The child was asked to surrender the shoelaces but refused. Program staff conducted a suicide risk assessment and due to the child's history and current behavior the child was determined to be moderate risk and was placed under enhanced supervision. This level of supervision meant the child's room was to be cleaned out and the child was to be supervised by program staff at all times. The child's room was never emptied as the child refused to cooperate.

A program supervisor interacted extensively with the child throughout the day and into the evening, trying to de-escalate the child and convince the child to stay in the program. A run risk prevention plan was attempted because the child was giving away belongings and continuing to make statements about leaving, but the child would not actively participate. The program supervisor left shift around 3 a.m. but was called back

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at 7 a.m. due to staff shortage. The program supervisor again engaged with the child and the child continued to escalate and make statements about leaving the program. The child denied being suicidal, however concerns remained due to behavior in the days prior. The staff supervisor allowed the child into an unrestricted and unsecured area of the program and the child left the program. The staff supervisor did not follow the protocol regarding children under enhanced supervision by physically preventing the child from leaving the program or calling police to assist in preventing the child from leaving. Once the child left the program, the program supervisor contacted required individuals to report. After the child left, program staff found a note in the child's room with instructions about the child's belongings and statements about other final arrangements.

The program supervisor who allowed the child to leave the program was released from employment shortly after the incident for not following established protocol.

On December 3, 2019, law enforcement was contacted after a citizen saw an individual hanging from a tree in a county park. It was determined the individual was the child. A letter was found identifying the child and making it clear the child's death was a suicide.

The allegation of neglect by the program supervisor was substantiated and the OTIS investigation closed on February 6, 2020. In the wake of the tragedy, the CCA responded with robust support for program staff and youth residents of the program through internal resources as well as the county's rapid response team. Additionally, support was offered to the child's family and the program supervisor involved in the incident.

The licensing agency for the CCA considered what actions, if any, were warranted or required in light of the violation of protocol by the supervisor and determined no action was necessary or mandatory.

### Description of relevant prior Department reports:

<b>Date of report:</b>	<b>Allegation(s):</b>	<b>Disposition(s):</b>
3/13/14	Neglect of the child and the child's five siblings by the mother and father	Unfounded
<b>Assignment decision:</b> Within 24 hours	Threat of Harm to the child's siblings by the child	Unfounded

On March 13, 2014 the Department received a report the child's parents were struggling to meet the safety needs of the child, age 13 ½, and the child's five siblings due to the

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child's problematic behaviors, in particular sexualized behavior. According to the report the child had been in counseling due to sexual acting out toward a younger cousin and was recently in trouble at school for sexually harassing female students.

The family was contacted, and all members were interviewed and/or observed. The parents expressed concern for the child's behavior and attachment to the family and requested assistance in meeting the child's needs.

Records reviewed indicated the child began taking medication for ADD at the age of seven but had tried at times to discontinue medication, without lasting success. The child disclosed feeling they were always in more trouble than the other children in the home.

The family was referred for Intensive Community Treatment Services, but the child refused to participate. A referral was made for treatment foster care and the assessment was converted to Family Support Services and remained open for several months. The case ultimately closed as no safety threat was identified and a placement was not secured. The parents sought support from extended family members in order to provide adequate supervision to the child.

<b>Date of report:</b>	<b>Allegation(s):</b>	<b>Disposition(s):</b>
5/14/15	Neglect of the child and the child's sibling by the mother and father	Unfounded
<b>Assignment decision:</b> Within 24 hours	Sexual Abuse of the child's sibling by the child	Unable to Determine

On May 14, 2015 the Department received a report concerning sexual abuse of the child's 4 ½ year old sibling by the child, age 14 ½ at the time.

The CPS assessment and law enforcement report described an incident in which the child touched the genitals of the 4 ½ year old sibling while the family was out at a local restaurant. The documentation also described prior incidents in which the child had acted out sexually toward a younger female relative. Further, the child had been excluded from school due to continued sexually harassing behavior toward other students.

The parents had been exercising close supervision of the child for some time and had made many adjustments to their lives since the 2014 assessment. The incident giving rise to this assessment happened during a small window of time. The parents

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responded swiftly, and the child and father went to stay elsewhere to prevent contact with the 4 ½ year old sibling pending the investigation.

At the conclusion of the assessment, it was determined to be unfounded for neglect by the parents and unable to determine for sexual abuse of the 4 ½ year old sibling by the child. The CPS caseworker documented difficulty in finding the child responsible for sexual abuse when the child had experienced sexual abuse and other trauma from an early age and had been exhibiting sexual behavior problems for some time. The child and family cooperated with the investigations and the child was ultimately placed in a treatment setting.

<b>Date of report:</b> 11/4/16	<b>Allegation(s):</b>  Neglect	<b>Disposition:</b>  Not Applicable
<b>Assignment decision:</b> Closed at Screening		

The Department received three calls on November 4, 2016. All were closed at screening as they were not reports of abuse.

1. Report of boundary concerns between the child and a peer while placed at the CCA. Program staff redirected the children.
2. Report that the child and a peer engaged in a confrontation, staff intervened.
3. Report that a peer entered the child's room and slapped the child in a playful manner. The child laughed and there was no injury.

<b>Date of report:</b> 11/20/16	<b>Allegation(s):</b>  Neglect	<b>Disposition:</b>  Not Applicable
<b>Assignment decision:</b> Closed at Screening		

Report of boundary concerns between the child and a peer. One child grabbed the other's wrist, they were told to separate, and they complied. This report was closed at screening as it was not a report of abuse.

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<b>Date of report:</b> 11/23/16  <b>Assignment decision:</b> Closed at Screening	<b>Allegation(s):</b>  Neglect	<b>Disposition:</b>  Not Applicable
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Report of the child and two peers engaging in “playful inappropriate touching and sexual humor”. This occurred despite appropriate staff supervision, this report was closed at screening as it was not a report of abuse.

<b>Date of report:</b> 1/4/17  <b>Assignment decision:</b> Closed at Screening	<b>Allegation(s):</b>  Neglect	<b>Disposition:</b>  Not Applicable
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The child reported to have “cheeked” medication with the intention of snorting it later. The program was not able to determine if the child did in fact cheek the medication and provided information as to their medication administration policy. There were no side effects noted to the alleged two missed doses. This report was closed at screening identifying this as a possible performance issue to be addressed by the program and not a report of abuse.

<b>Date of report:</b> 2/4/17  <b>Assignment decision:</b> Closed at Screening	<b>Allegation(s):</b>  Neglect	<b>Disposition:</b>  Not Applicable
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The child reportedly shoved a peer while playing basketball. This report was closed at screening as it was not a report of abuse.

<b>Date of report:</b> 2/24/17  <b>Assignment decision:</b> Closed at Screening	<b>Allegation(s):</b>  Neglect	<b>Disposition:</b>  Not Applicable
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It was reported the child went up behind a peer and “dry humped” the peer while both were fully clothed. Program staff were present and intervened immediately. This report was closed at screening as it was not a report of abuse.

<b>Date of report:</b> 2/28/17	<b>Allegation(s):</b> Neglect	<b>Disposition:</b> Not Applicable
<b>Assignment decision:</b> Closed at Screening		

Another child at the program hugged the child multiple times. This report was closed at screening as it was not a report of abuse.

<b>Date of report:</b> 3/7/17	<b>Allegation(s):</b> Neglect	<b>Disposition:</b> Not Applicable
<b>Assignment decision:</b> Closed at Screening		

It was reported the child and peers were being rowdy and not responding to staff. The child was playing music loudly and instigating peers. This report was closed at screening as it was not a report of abuse.

<b>Date of report:</b> 3/7/17	<b>Allegation(s):</b> Neglect	<b>Disposition:</b> Not Applicable
<b>Assignment decision:</b> Closed at Screening		

The Department received a call concerning the child’s sibling, age 15. The caller reported the child’s sibling was making statements about jumping off the building and said the mother punched the sibling in the face. The sibling was not injured and did not appear distraught. The sibling made similar comments in the past. It was reported the psychiatrist adjusted the sibling’s medication at that time and the comments ceased. The sibling was reported to have a traumatic brain injury and was relating the information in a story-like manner. There were no other concerns about the sibling’s emotions or behaviors. The parents were reported to be active with the children and no other concerns were noted. The report was closed at screening.

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<b>Date of report:</b> 3/8/17  <b>Assignment decision:</b> Closed at Screening	<b>Allegation(s):</b>  Neglect	<b>Disposition:</b>  Not Applicable
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It was reported the child and several peers were being non-compliant, turning up music very loudly, running around and yelling. The children were also talking about doing drugs and making crude comments about sex. At one point the children eloped from the campus returning two hours later. Police were contacted. This report was closed at screening as it was not a report of abuse.

<b>Date of report:</b> 9/27/18  <b>Assignment decision:</b> Within 5 days	<b>Allegation(s):</b>  Neglect by Child Caring Agency employees	<b>Disposition:</b>  Substantiated
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On September 27, 2018 OTIS was assigned a report alleging neglect of the child due to lack of supervision resulting in the child and another resident of the program engaging in inappropriate sexual behavior and substance use.

Both children were interviewed and admitted to sneaking away during times when staff supervision was limited to engage in inappropriate sexual behavior. The child also disclosed smoking marijuana with another resident when staff supervision was limited. Records and interviews with program staff indicated lapses in supervision at times. Although no specific individual was determined to be responsible, the investigation did result in a substantiated finding of neglect by the program. It was also noted, during this investigation, that the child was hospitalized for a short period while in the program due to emotional distress and concerns of self-harming behavior.

<b>Date of report:</b> 2/17/19  <b>Assignment decision:</b> Closed at Screening	<b>Allegation(s):</b>  Neglect	<b>Disposition:</b>  Not Applicable
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Report that the child and a peer engaged in a verbal altercation which led to the child entering the peer's room and punching the peer in the ribs. Although staff intervened during the verbal dispute, the physical altercation occurred later and was undetected

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by staff. This contact occurred despite appropriate supervision and the report was closed at screening.

<b>Date of report:</b> 6/28/19	<b>Allegation(s):</b> Sexual Abuse by a Child Caring Agency employee	<b>Disposition:</b> Unsubstantiated
<b>Assignment decision:</b> Within 5 days		

On June 28, 2019, OTIS was assigned to investigate a report of sexual abuse of the child and others at a CCA. According to the report, a female staff person was sexually abusing children during one on one time. The child and other alleged victims were interviewed and made no disclosures of abuse. The alleged perpetrator was also interviewed. She adamantly denied the allegations and described her interaction with children in the program and her efforts to document activities and any concerns. There was no evidence to support the allegation and the report was closed unsubstantiated.

This investigation was complete but had not yet been closed in the Department's information system at the time of the fatality.

### **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 death of a child by suicide has devastating impacts to the community. Everyone who interacted with a child lost to suicide wonders what more they could have done, but there is rarely a singular answer to the question. This child's lifetime was fraught with struggle, including early childhood trauma, sexual behavior problems, substance use, depression, and suicidal ideation. Many systems interacted with this child in attempts to address these needs over the years. In light of the historical information impacting this child and the child's circumstances, the CIRT would be remiss to narrow the lens to one action on one day.

The CIRT made the following observations upon review of this case.

The youth suicide rate in Oregon (per 1,000 among 10 to 24-year-olds) continues to trend upward, yet prevention and intervention remains underfunded. Knowledge about suicide prevention, intervention and treatment is limited among those who provide critical services to vulnerable children. The behavioral health system is not robust

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enough to support those children who are identified at risk of suicide and in need of intervention and treatment services.

Child Caring Agencies, specifically Behavioral Rehabilitation Services (BRS) programs, are required to ensure staff members are trained in suicide awareness and risk assessment, but there is limited support once a child has been identified as at risk and remains in the program. Protocols are in place to assist staff members in making immediate decisions to ensure safety of a child, but support for ongoing intervention is not consistently available within the service array once the emergency of the initial threat has passed.

### **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 child in this case was not in the custody of the Department and the Department had no influence on planning for the child in the four years preceding the death. The CIRT did not have recommendations specific to the administration of child welfare services but discussed larger system issues related to suicide prevention and intervention and the epidemic of youth suicide.

The creation of the Child Fatality Prevention and Review Program within Child Welfare allows for expansion of prevention efforts. Suicide prevention is a focus area of this new program and concerted efforts will be made to identify opportunities for engagement with partners across the broader child and family serving system.