

Critical Incident Review Team Case File Summary



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.

CIRT ID: V93KCW0YQF		
Date of critical incident: May 6, 2020	Date Department became aware of the fatality: May 7, 2020	
Date Department caused an investigation to be made: May 6, 2020	Date of child protective services (CPS) assessment disposition: August 11, 2020	
Date CIRT assigned: May 8, 2020	Date Final Report Submitted: August 14, 2020	
Date of CIRT meetings: May 22, 2020 July 10, 2020	Number of participants: 13 15	Members of the public? 0 0

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

Date of report: 05/06/2020	Allegation(s): Neglect by Mother	Disposition(s): Unfounded
Assignment decision: Within 24 Hours		

On May 6, 2020, The Department received a report regarding the attempted suicide of the 13-year-old child while at the mother's residence. It was reported the child primarily resided with the paternal grandparents and had recently begun spending more time in the mother's home. The day of the critical incident, the child was at the mother's residence reportedly in the care of three other adults as the mother had left the home with a friend for the evening. Approximately ten minutes after the mother left the residence, an adult in the home found the child had attempted suicide by hanging. The mother was contacted and quickly returned to the residence.

The child received assistance from emergency medical personnel and was ultimately admitted to a Pediatric Intensive Care Unit as the child's prognosis for survival was poor. The report stated that while at the hospital the mother was distraught at times but also presented with a somewhat flat affect. The child was admitted to the local hospital late in the evening. The mother stayed with the child for a short time before returning to her vehicle. Hospital staff located the mother in her vehicle asleep and were unable to wake her for some time.

The report stated the mother indicated the child had a history of suicidality at which time the child sought assistance from a suicide hotline as well as school counselors and had been evaluated by mental health professionals. The report also stated that while the mother had previously worked with mental health providers for the child it was also reported the mother previously believed the child's suicidal statements were an attention seeking behavior.

As part of the CPS assessment, the CPS caseworker obtained the law enforcement record regarding the critical incident. The record stated that before the mother departed the residence, she put the child to sleep on a couch in the living room, leaving the child in the care of adults who remained in the home. The report stated that nothing seemed to be out of the ordinary when the mother left though the child had been frustrated that the mother asked the child to turn off the television and go to sleep. However, it was also reported that since the mother's recent contact with law enforcement and the subsequent

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execution of a search warrant at her home, the child had been noticeably sadder, possibly because the child's routine had been altered.

The adults in the home at the time of the incident reported the child had been left alone for approximately five minutes before being found having hung themselves from a ceiling hook in the living room. The adults administered CPR while waiting for emergency personnel to arrive. During that time, the mother was contacted and returned to the residence.

Upon receiving the news the child had attempted suicide, the CPS caseworker contacted the paternal grandparents and learned they were at the hospital with the mother. The child's father was not present as he was incarcerated for drug related charges. The CPS caseworker traveled to the hospital and was able to observe the child however due to the seriousness of the child's condition, no interview could occur.

During the evening of May 6, 2020, the Department was notified the child had died.

To further understand the critical incident, the CPS caseworker contacted the individuals who were caring for the child the evening of the suicide. These individuals confirmed the child was in their care because the mother had left the residence with a friend for the evening. No concerns were reported regarding the child's behavior leading up to the incident.

Additional collateral contacts were made during the course of the CPS assessment to gather information regarding the child's functioning. Staff at the child's school reported the child received a number of special education services due to the child's autism diagnosis. One staff person reported the child struggled with becoming fixated on thoughts and previously had episodes in which the child experienced suicidal ideation while at school. When this occurred, the child required redirection to cease the suicidal ideation. Staff reported they had many interactions with the child's grandparents and had no concerns regarding their care of the child.

The Department determined the allegation of neglect to the child by the mother was unfounded as the mother's actions were appropriate as she had left the child in the care of adults and at the time of the incident there were no clear indications the child was experiencing suicidal ideation.

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Description of relevant prior Department reports:

Date of report: 08/09/2005	Allegation(s): Neglect & Physical Abuse by Mother	Disposition(s): Founded
Assignment decision: Within 5 Days		

On August 9, 2005, the Department received a report of concern for the mother's newborn as a result of the mother's reported drug use and lack of stable housing. In addition, the mother was reportedly a survivor of domestic violence. The report stated the half sibling to the deceased child listed above was born prematurely and was to remain in the neo-natal unit for a number of weeks.

During the CPS assessment, the CPS caseworker was informed the infant tested positive for Methamphetamine. While speaking to the CPS caseworker regarding the positive drug screen, the mother denied Methamphetamine use but stated she had used Marijuana recently. The mother presented as very cooperative and expressed a desire to work with the Department in any way necessary.

The Department concluded the allegations of neglect and physical abuse (poisoning) to the half sibling by the mother were founded as the child tested positive for Methamphetamine at birth.

During the course of the mother's contact with the Department, she was offered multiple services however she failed to engage in these services. The half sibling was ultimately raised by family members due to ongoing concerns regarding the parents' failure to address safety concerns.

Date of report: 11/14/2005	Allegation(s): Threat of Harm by Mother	Disposition(s): Not Applicable
Assignment decision: Closed at Screening		

On November 14, 2005, the Department received a report of concern regarding the mother. The report stated the mother did not have a stable residence and was residing with a friend who was believed to be an active substance user however the reporter had not witnessed recent drug use by either the mother or her friend. The report noted the mother's only child tested positive for substances at birth and was not currently in

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her care. The Department closed the report at screening as the mother was not currently caring for her child.

Date of report: 04/20/2006	Allegation(s): Threat of Harm Neglect & Physical abuse by Mother	Disposition(s): Not Applicable
Assignment decision: Closed at Screening		

On April 20, 2006 the Department received a report which stated the mother was expecting her second child in late August and while reportedly receiving prenatal care, the medical provider was unknown. The reporter expressed concern for the mother's ability to care for the child as the child's half sibling, who the mother was not currently caring for, had tested positive for substances at birth and the mother had not engaged in services provided by the Department. The report was closed at screening as the mother was not currently caring for a child.

Date of report: 07/27/2006	Allegation(s): Threat of Harm Neglect & Physical Abuse by Mother	Disposition(s): Unable to Determine
Assignment decision: Within 24 Hours		

On July 27, 2006, the Department received a report the mother had given birth to a baby who tested negative for illegal substances. The child's father was reported to be very supportive and appropriate. It was noted the mother's oldest child tested positive for illegal substances at birth.

The case record indicated the mother had not engaged in services to address concerns during previous involvement with the Department.

While at the hospital, medical staff reported no concerns regarding the mother or her care of the child. During the CPS caseworker's initial contact with the mother at the hospital, the mother reported she would be engaged in supportive services through a community agency until September 2006. When asked about her failure to complete services with the Department, the mother reported she had been in and out of jail and had not been stable enough to complete a program but had been participating in some services through her work release center. The mother expressed a desire to engage in services and agreed to work voluntarily with the Department to access additional services.

The mother reported the plan for the child was for the father and paternal grandmother to provide care for the child in the paternal grandmother's home while the mother

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completed her work release program. Once the program was completed, the mother planned to join the father in the paternal grandmother's home and actively parent the child. The paternal grandmother reported the family planned that she would be the primary caregiver for the child until the mother was released, at which time she would support the mother in her parenting. The paternal grandmother also reported that if either parent appeared to be using substances, they would be removed from the home and would not provide care for the child.

The CPS caseworker contacted the father who reported he had been engaged in services through a county provider for several months. He reported it had been over a year since he used Methamphetamine and that he had not smoked Marijuana since May. The father confirmed the family's plan for his mother to provide primary care for the child and stated he believed it was important for the mother to complete services with the Department.

Through collateral contacts with partner agencies, the CPS caseworker learned the father was recently incarcerated for a number of days due to failing to comply with his probation requirements. Despite the incarceration, the father's probation officer reported no concerns regarding the father's ability to parent.

As the CPS assessment progressed, the parents determined they did not wish to work with the Department and were therefore informed they had the ability access services with the Department in the future if they desired. The CPS caseworker noted that while the case was at very high risk for future action by the Department, the allegation of threat of harm to the child by the mother was unable to determine as the mother and child tested negative for substances at the birth and the mother had been participating in community services.

Date of report: 01/12/2007	Allegation(s): Threat of Harm by Mother	Disposition(s): Not Applicable
Assignment decision: Closed at Screening		

On January 12, 2007, the Department received a report that the mother may not have been following the Department agreed upon plan regarding the child. The report stated the mother was to be living with a relative who would supervise her interactions with the child however the reporter stated the mother may in fact be living in a different city. The Department closed the report at screening stating there was insufficient information to conclude that the mother was violating the plan however if additional information was received that the mother was residing with the child and had no supervision, a new assessment would be generated.

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Date of report: 05/23/2012 Assignment decision: Closed at Screening	Allegation(s): Threat of Harm by Mother	Disposition(s): Not Applicable
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On May 23, 2012, the Department received a report of concern regarding the 5-year-old child in the care of the parents. The report stated local law enforcement received a report that the child had been neglected due to parental substance use. It was reported the mother left the home unexpectedly for a number of days and when she returned, she was believed to be under the influence of Methamphetamine which was reported to have been confirmed through a positive drug test.

The report went on to state that law enforcement conducted a welfare check at the family's home. During the contact the father reported he and the mother had been arguing which prompted her to leave the residence. When she returned, the mother was under the influence of Methamphetamine, which she had recently resumed using. The father disclosed he smoked Marijuana occasionally and subsequently allowed officers to search the residence. No illegal substances were located. The mother also spoke to law enforcement and admitted to recent Methamphetamine use and agreed to cooperate with her family to access appropriate services. Law enforcement personnel noted no concerns regarding the father's ability to provide care for the child and reported the child appeared to be in good health and receiving appropriate care.

The Department concluded there was no information the mother was using illegal substances in the home or that her parenting was impaired, and no concerns were reported regarding the father's ability to care for the child therefore, the report was closed at screening.

Date of report: 06/07/2018 Assignment decision: Within 24 Hours	Allegation(s): Physical Abuse by Father	Disposition(s): No Allegation of Abuse/Neglect
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On June 7, 2018, the Department received a report of concern regarding the 11-year-old the child. The report stated that while in school that day, the child made statements to their class that they wanted to commit suicide and then began pressing an educational tool to their chest resulting in a number of small marks. The report stated that when questioned regarding the comments, the child reported their father pushes them as a form of discipline and that they felt the father behaves in a bullying manner. The child reported having bruising to their back, though none was observed. The child

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also relayed a story in which the father pushed them causing them to fall backwards into a light switch. The report also noted the child received special education services and had difficulty relaying information.

On June 8, 2018, the CPS caseworker contacted school personnel to gather additional information regarding the reported incident. Staff reported the child was diagnosed as on the autism spectrum and received one-on-one support to address academic and behavioral needs. Regarding the incident in question, the school staff reported the child became frustrated with the class project and began making statements about wanting to commit suicide. School staff took the child to the school counselor who attempted to conduct a suicide threat assessment. During the conversation, the child was unable to indicate a time or date for when the father pushed them, possibly due to the child's presentation of autism. The counselor was able to confirm the child did not have current injuries. The child informed school personnel that the father had pushed them on two occasions and that they felt the father was a bully.

The CPS caseworker learned the child had made a similar suicidal statement approximately six weeks prior. During that incident the mother was contacted by the school and responded appropriately. School staff suggested the child should be seen by a local mental health provider. The mother and school staff completed a telephone intake for mental health services with the understanding that the provider would be able to expedite an assessment appointment for the child.

The Department determined the allegation of physical abuse to the child by the father was closed with no allegation of abuse as the child had not received an injury from the reported pushing by the father and while the child participated in superficial self-harm when frustrated in school, the Department determined the parents appropriately addressed the child's mental health concerns.

Date of report: 04/16/2020 Assignment decision: Within 72 Hours	Allegation(s): Threat of Harm by Mother	Disposition(s): Unable to Determine
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On April 16, 2020, the Department received a report of concern regarding the 13-year-old child while in the care of the mother. The report stated that Methamphetamine, drug paraphernalia and residue of Heroin and Marijuana were located in the mother's residence. The drugs and paraphernalia were reported to be located in an area accessible to the child. However, the child reportedly only resides with the mother on occasion and was in the care of the grandparents at the time the drugs and drug paraphernalia were

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found. It was also reported that the mother provided Methamphetamine to a 16-year-old and that the mother was actively using Methamphetamine. Additionally, the report noted the mother was recently stopped by law enforcement for driving a stolen vehicle.

On April 17, 2020, the CPS caseworker met with the mother at her residence however the child was not present. The mother reported the child primarily resided with the grandparents but visited her home on occasion, most frequently on weekends. Regarding the reported concerns of drugs use and drug paraphernalia accessible to the child, the mother adamantly denied any drug use and reported the drug paraphernalia found in the residence belonged to others.

A law enforcement report obtained by the Department during the course of the CPS assessment detailed law enforcement's contact with the mother and concerns regarding her involvement with illegal activities. On April 14, 2020, the mother was stopped by police for driving a stolen vehicle which she denied being aware was stolen and reported having purchased earlier that day. During the interaction, law enforcement found the mother to be in possession of stolen checks and she was subsequently transported to the police station. The minor female passenger present in the vehicle during the law enforcement contact reported the mother had provided her Methamphetamine and that she had used Methamphetamine with the mother at the mother's residence. As a result of this information, law enforcement executed a search warrant at the mother's home.

During the search, officers found multiple items in the garage believed to be related to illegal substance use including baggies, knives and spoons, all of which contained what appeared to be drug residue. Also located in the home were two smoking devices with white crystalline residue believed to be Methamphetamine. The mother was issued citations in lieu of custody for Forgery 2, Criminal Possession of a Forging Instrument 2, and Unauthorized use of a Vehicle.

After multiple unsuccessful attempts, the child was contacted on May 5, 2020, by a CPS caseworker who was present at the mother's home addressing a companion case regarding the mother's roommate.

On May 6, 2020, the Department received a report regarding the child's suicide attempt which initiated a new CPS assessment. The two open CPS assessments were subsequently combined. Assessment activities occurring after May 6, 2020, are captured under the CPS assessment created on that date.

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Description of relevant prior Department reports for the father and his previous partner (not the mother of the deceased child):

Date of report: 03/15/2019	Allegation(s): Neglect by Father and Father's Significant Other to the Significant Other's Child	Disposition(s): Unfounded
Assignment decision: Within 24 Hours		

On March 15, 2019, the Department received a report of concern regarding the 12-year-old child of the father's significant other. The report stated the father and his significant other, with whom he did not reside, use Marijuana. The report stated that while the father's significant other did not use Marijuana in the presence of her child, the father had smoked Marijuana in the presence of his significant other's child and had driven a vehicle with that child present while he was smoking Marijuana. The report noted the father had his own child (the deceased child identified above) though the level of contact between the father and his own child was unknown.

During the course of the CPS assessment, the CPS caseworker was informed by the child of the father's significant other that while they did not care for the father, the report of the father using Marijuana in their presence was not true and said out of anger. It was also discovered that the father was no longer in a relationship with his significant other.

The Department concluded the allegation of neglect to the child of the father's significant other by their own mother (the father's significant other) and the father was unfounded as no disclosures of neglect were made during the course of the assessment and the relationship between the father and his significant other had ended.

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 determined no actions or lack of actions by the Department contributed to the child's death. The Department recognizes suicide is a national leading cause of death for children. In Oregon, significant efforts to address this public health crisis have included Oregon Health Authority's 5-Year Youth Suicide Intervention and Prevention Plan and recent legislation requiring public education systems to offer suicide awareness training and postvention plans. The Department has also taken steps to provide education and awareness for staff, community partners, and families served by child welfare.

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Beginning in 2017, the Department partnered with Oregon Health Authority to provide suicide prevention and awareness education. Subsequently, Question, Persuade and Refer (QPR) training was offered to hundreds of Child Welfare staff members. This culturally sensitive evidence-based training has been used internationally to support suicide prevention. In an effort to expand training efforts, the Department partnered with QPR Institute and acquired a computer-based version of QPR. This virtual training will be offered to Child Welfare starting in September of 2020 with the goal of reaching all Social Service Specialists and their supervisors by December 2021 and ultimately all Department employees, approximately 9,800 staff.

The Department is committed to continuing its partnership with OHA and is exploring additional ways to support other suicide awareness efforts within the public education and behavioral health systems.

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 recommendations for improvement in the administration and oversight of the child welfare system that are specific to the critical incident or the historical information reviewed by the team.