Critical Incident Review Team Final Report (Discretionary)

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 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.

While this fatality was not reasonably believed to be the result of abuse or neglect, the Director requested a Discretionary CIRT be assigned based on the multi-system involvement with this family and the opportunity for system learning from this tragic outcome.

DISCRETIONARY CIRT ID: X00QOXOB04		
Date of critical incident: 02/04/2020	**Date Department became aware of the fatality:** 02/13/2020	
Date Department caused an investigation to be made: Not Applicable- Closed at Screening	**Date of child protective services (CPS) assessment disposition:** 04/21/2020	
Date CIRT assigned: 02/26/2020	**Date Final Report submitted:** 05/26/2020	
Date of CIRT meetings: 04/09/2020	**Number of participants:** 21	**Members of the public?** Yes

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

Date of report: 02/13/2020 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect by the mother	**Disposition:** Not Applicable

On 02/13/2020 the Department received a report that a 17-year-old child was found deceased on 02/04/2020.

The child had been hit by multiple vehicles when walking down the highway. The child was identified as a runaway/homeless youth at the time of their passing. The child's mother was aware of the death prior to Department notification.

The report was Closed at Screening, as the fatality was not the result of abuse or neglect. There was an open child abuse assessment at the time of the hotline call and that caseworker was notified of the report.

Description of relevant prior Department reports:

Date of report: 06/02/2016 **Assignment decision:** Assign- 24 hours	**Allegation(s):** Sexual Abuse by Sibling 1 Threat of Harm by Sibling 1	**Disposition:** Unfounded Unfounded

On 06/02/2016 the Department received a report that the child had been sexually abused by their 15-year-old sibling, two to three years earlier. Reportedly, the abuse occurred only once and at a relative's home.

The CPS caseworker interviewed all three children and the mother in person and spoke with the stepfather by telephone. According to the information provided during the assessment, the reported incident occurred when the child was 9 years old and the sibling was 11 years old. The family was at a relative's home when the children were playing hide-and-seek in a closet and the sibling briefly fondled the child.

The CPS caseworker also gathered medical and mental health records for the child during this assessment. The child was regularly seeing a physician. It is unclear how regularly the child saw their mental health provider. The mother expressed concern to the providers about the child's behavior. It was learned that the child was hit by a car while riding their bike in October 2015. The child was diagnosed with Major Depressive Disorder and Post Traumatic Stress Disorder and was being treated with medication and therapy. Providers discussed options for more intensive mental health treatment for the child, but the family declined those services. The child was skipping school and had spent a few weeks lodged in the juvenile detention facility.

The Department determined the allegation of sexual abuse was unfounded due to the close age of the children at the time and belief that the incident was no more than exploratory. Both children were described as scared by the incident and the family was reported to have taken appropriate steps to intervene.

Date of report: 05/18/2017 **Assignment decision:** Assign- 24 hours	**Allegation(s):** Mental Injury by the mother as to Sibling 1	**Disposition:** Unfounded

On 05/18/17 the Department received a report that on 05/15/17 the child's older sibling engaged in self-harming behavior and the mother had reportedly made statements which may increase the sibling's self-harming or aggressive behaviors. Paramedics responded to the family home, where the sibling was found to have injured themselves and damaged the home. Paramedics heard the mother belittling the sibling and the sibling became agitated. The sibling told hospital staff that when they were cutting, the mother instructed them to cut deeper. The sibling had recently gone to juvenile detention after a physical confrontation with the mother. They had also been hospitalized for stabbing themselves in the leg, earlier in the year.

The CPS caseworker conducted interviews with all three children, as well as the mother and stepfather. The sibling denied that their mother made derogatory statements to them. The sibling expressed feeling better and talked about engaging in counseling. Records from the sibling's therapist did not indicate that they were fearful of their mother nor that she ever made derogatory statements to the children. The other children in the home expressed feeling safe and made no disclosures of abuse or neglect.

The stepfather reported that on the day of the incident, the sibling was in a bad mood and that when the mother tried to talk to them, they became angry. The stepfather reported that the sibling had anger problems. He denied the mother spoke negatively to the sibling but said that they did argue. The mother reported that if she knew she would be reported for trying to get help for her child she would have taken them to the hospital

herself. The mother denied saying the comments she was alleged to have said. She reported that she is very supportive of her child and gets them outside assistance when needed. Both adults reported that the situation had improved, as the sibling was on medication and sleeping better.

The CPS caseworker gathered and reviewed medical and mental health records for the sibling during this assessment. Mental health records indicated the sibling had been seen by their counselor multiple times beginning in October 2016 through April 2017.

It was learned during this assessment the father of the child and their older sibling was homeless and had not seen or spoken with the children for a very long time.

The Department determined that because no information was gathered that would indicate that the mother made disparaging comments to the sibling, the assessment was unfounded for mental injury by the mother.

Date of report: 02/14/2018 **Assignment decision:** Assign- 24 hours	**Allegation(s):** Mental Injury by the mother as to Sibling 1 Physical Abuse by the mother as to Sibling 1	**Disposition:** Unfounded Unfounded

On 02/14/2018 the Department received a report that the older sibling was being hit by their mother when she was angry or frustrated with the sibling. The mother reportedly caused injuries to the sibling, from jewelry on her hand. It was also reported the mother encouraged the sibling to kill themselves. At the time of the report, the sibling was in custody at a local juvenile detention center for Criminal Mischief, regarding damage to the mother's property.

The CPS caseworker had contact with the children and the mother. The older sibling reported that their mother yells at them and makes statements that they should kill themselves or "cut deeper". The sibling reported their mother hit them with her ring. They did not think it was intentional or that she tried to hurt them. It is unknown how many times the sibling was hit. The sibling acknowledged they had recanted similar allegations before. The sibling reported that they get along well with the stepfather. The sibling denied needing mental health services but acknowledged struggling with anger issues.

The child and younger sibling both reported witnessing the older sibling's behaviors but denied seeing their mother harm the older sibling.

The mother admitted to slapping the older sibling when the sibling threatened the lives of the mother and other children and when the older sibling was being destructive in the home. She expressed frustration and desire to have the older sibling return home and receive mental health services.

When law enforcement was interviewed, the CPS caseworker spoke to an officer who reported they could hear yelling and pounding, and the windows were vibrating when they arrived at the home. It was reported that the sibling was on a “rampage” again which they described as normal. The officer reported the sibling has outbursts at school too. The officer indicated the older children were out of control at times and the family had financial struggles. The officer stated when they asked the mother if she wanted to press charges, she told them no. So, the sibling had not been taken into custody. The officer was aware of the sibling’s mental health issues. The officer denied ever seeing signs of physical abuse on the children.

The Department determined that the allegations for mental injury and physical abuse were unfounded. The sibling made threats to cause harm to the family and while the mother admitted to slapping them, there were no reported injuries. This assessment identified the family as having moderate to high needs and the CPS caseworker offered services to the family, but they were already engaged in such services and declined additional services.

Date of report: 08/06/2018 **Assignment decision:** Assign- 24 Hours	**Allegation(s):** Neglect by the mother as to Sibling 2	**Disposition:** Unfounded

On 08/06/2018, the Department received a report that the child ran away from home several times. The child had reportedly stated they would not stay at home and would continue to run. According to the reporter, the child punched their mother in the chest and ran away. Law enforcement picked the child up but did not detain them. The child was described by law enforcement as unsafe because they continue to run away from home and engage in high risk behaviors. Law enforcement requested Child Welfare take responsibility in assisting to provide care for this child who they deemed as unsafe and at risk for sex trafficking. The report was assigned to investigate neglect to Sibling 2 based on the child’s high-risk behaviors.

During the CPS assessment it was learned that that the child did not wish to return home due to their older sibling’s behaviors and parental alcohol and marijuana use.

When law enforcement released the child, the CPS caseworker attempted to facilitate contact between the mother and child to create a plan. The child wished to go with a relative and the mother wished for the child to return home. The CPS caseworker

provided the family with other resources, such as shelter options. It was determined there was no reason to legally intervene and the CPS caseworker informed the mother that the family would need to make a plan for the child. The child decided to go to an unidentified friend's home but refused to provide further details to the CPS caseworker.

The mother expressed concerns about the child continuing to engage in high risk behaviors. The mother reported trying counseling and other disciplinary tactics, which she felt were not effective. The mother reported that if the child brings unsafe people to the home, the mother has the child trespassed. She reported having the child taken to the local shelter.

The younger sibling reported seeing the older children be aggressive and violent to themselves or others on multiple occasions. The older sibling did not disclose any safety concerns in the home. At the time of this assessment the older sibling was not residing in the home as they had been kicked out due to their behavior. The older sibling was reportedly residing with a relative.

At the close of the assessment, the child was missing from the family home. Their information had been provided to National Center for Missing and Exploited Children and local law enforcement.

This assessment was completed using the Overdue Protocol and was closed as unfounded for neglect by the mother to the younger sibling. It was determined that the mother had taken appropriate steps to protect the younger child when the older children were behaving aggressively.

Date of report: 11/28/2018 **Assignment decision:** Closed at Screening	**Allegation(s):** Sexual Abuse by an Unknown Perpetrator Neglect by the mother as to Sibling 1	**Disposition:** Not Applicable Not Applicable

On 11/28/2018 the Department received a report that the child disclosed being raped by an older man while sleeping. The child reported telling law enforcement about this and indicated the officer said they only needed to report it if they wanted to. The child reportedly said they didn't see a need to make a report. The child also reported two years ago their boyfriend raped them and continuously tried to do things to them while they were sleeping. There was no identifying information for the boyfriend.

A second reporter stated that the older sibling was sleeping in the woods behind the family home, under a tarp because they are fearful to go home. The mother reportedly

told the older sibling that she would call police because she found drug paraphernalia in their room and the sibling was on probation. The older sibling reportedly stated if they had to go back to jail, they would kill themselves. The reporter stated that the mother is fed up with her children and told the older sibling they better “hide deep” because they are going to jail for a long time.

The call was Closed at Screening. According to the screener, there was no indication the children were being abused or neglected. It was further determined that the allegation of sex abuse did not require a CPS assessment because the alleged perpetrator did not have access to the child and the mother was willing and able to protect the child.

Date of report: 11/29/2018 **Assignment decision:** Closed at Screening	**Allegation(s):** Threat of Harm by an Unknown Perpetrator	**Disposition:** Not Applicable

On 11/29/18, the Department received a report that the child was in a relationship with a 30-year-old male. Identifying information for the male was unknown. The child reported they were in love and that the adult had sent suggestive photos to them. It was reported there had been no further contact between the child and this male since law enforcement and DHS got involved. The child also reported that they had many relationships with adults who buy them drugs and alcohol.

The child reported they called 911 on their mother because the mother was abusive. The mother reportedly stated they have already been investigated and cleared of this. The mother reported that the child cannot stay with a relative because that relative may be struggling with substance abuse.

This call was Closed at Screening as it related to third party sexual abuse by an unknown perpetrator.

Date of report: 12/24/2018 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect by the mother	**Disposition:** Not Applicable

On 12/24/2018 the Department received a report that the child had run away from home and was in another county. It was further reported that the older sibling had

been living in the home until recently, when the mother kicked them out because they broke something and there was an argument. The reporter stated that the mother would not allow the older sibling back into the home. The older sibling was reported to be staying with relatives. It was reported that multiple parties had concerns that the mother has been verbally abusive and contributes to the discord in the home.

This report was Closed at Screening because the screener believed the information did not constitute a report of abuse or neglect.

Date of report: 01/18/2020 **Assignment decision:** Assign 24 hours	**Allegation(s):** Neglect by the mother	**Disposition:** Unfounded

On 01/18/20, the Department received a report that the child brought themselves into the emergency department on 01/17/2020 under the influence of methamphetamine. It was reported the child may need to be admitted to a psychiatric hospital. The reporter stated that the child did not have the capacity to make safe decisions and the hospital did not have a parent who was willing or able to take care of the child upon discharge. When speaking with the child's mother it was learned that the mother reportedly has not had contact with the child for two years, as the child had been living on the streets. The mother indicated she could not help the child because there was a younger child in the home. It was reported that the mother said the child was violent the last time they were in the home and the mother no longer felt comfortable having them there. The mother offered to come to the hospital to offer support but stated that the child could not come home with her.

Face to face contact by a CPS caseworker was attempted with the child on 01/19/2020 at the hospital. Hospital staff were busy at the time the CPS caseworker arrived. The worker was unable to wait due to other commitments and asked hospital staff to call them when the worker could see the child. The CPS caseworker did not receive a call before the end of the day and did not return to the hospital. On 01/20/2020, DHS was informed that the child had been discharged from the hospital the night prior. The CPS caseworker again attempted contact at the hospital, but it was confirmed that the child had indeed been discharged. The CPS caseworker was not provided further details on the child's contact information or where they may be.

The CPS caseworker made phone contact with the mother. She was not agreeable to a CPS caseworker coming to her home or interviewing the younger sibling. The

mother stated she has been through this before and there is nothing DHS can do to help. She reported that she had sought help from different agencies before but did not receive the help she needed for her child. The mother reported that she had driven around and looked for the child on multiple occasions but was never successful locating the child. The mother reported she received a call from the hospital, asking her to come pick up the child. The mother reported the hospital would not provide details on the child's condition. She expressed that she needed time to think about it, and the child was discharged before the mother could decide. The mother expressed frustration and sadness.

During this assessment the CPS caseworker reviewed local law enforcement reports. The child was residing outside their home area in various homeless camps prior to their passing. Law enforcement documentation indicated officers had contact with the child on at least six occasions between October 2019 and January 2020, none of which were cross reported to the Department. On all occasions the child was warned or cited for prohibited camping. The child was often found with adult men, including a significantly older man on multiple occasions.

During this assessment the CPS caseworker reviewed medical records for the child. The child was hospitalized at a local emergency department beginning on 01/16/2020 and discharged on 01/19/2020. The child came into the hospital with a mental health crisis but did not meet criteria for admission to inpatient psychiatry. The child reported daily methamphetamine use, last using methamphetamine on 01/15/2020 and the urinalysis was positive for methamphetamine and THC. The child reported to medical providers that they ran away from home when they were 15 years old and have been living on the streets. The child reported coming to the hospital because they believed that a male companion was brainwashing them. The child stated that they were quite fearful and paranoid and were experiencing auditory hallucinations. While in the hospital, the child was informed that DHS had been contacted. The child expressed that they did not want to wait for DHS to come before being discharged. Medical records indicate that the child's mother was also contacted and that the mother offered to pick the child up, but that she did not think the child would agree to go with her.

According to medical records, the child was in the emergency department again on 02/02/2020. The child was brought in by the local crisis response team after they found the child wandering and running into the street. The child was described as agitated and needing sedation. According to the notes, the child was discharged on 02/03/2020 and medical provider notes indicated that the child was ready to go to a local shelter. The provider encouraged the child to return to the emergency department if their symptoms worsened. The child reportedly denied any suicidal ideation at discharge.

During this assessment the Department learned of the child's death, after which the CPS caseworker had two calls with the mother. The mother expressed grief over

the loss of their child and frustration with the Department. The CPS caseworker also attempted to contact the older sibling, though that sibling did not have a working phone. The CPS caseworker did not have face to face contact with any family members during this assessment.

Collateral contact was made with the younger sibling's school. It was reported that the sibling is energetic, smart and funny. The school reported that the sibling has terrible attendance.

Though the child was identified as a missing child by collaterals during this assessment, it was learned that the child had not been reported as a missing child to local law enforcement or the National Center for Missing and Exploited children since 2018.

It was determined that the mother sought more information to make an appropriate decision for the child, after being contacted by the hospital, but was unable to get that information before the child was discharged. The Department also considered the history of the child being violent and aggressive in the family home. The allegation of neglect by the mother was unfounded at the close of the assessment.

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:

This child and family reflect common barriers encountered by the Department and the larger system serving children and families. The child experienced trauma and struggled with mental health symptoms, behavioral issues, substance use, and delinquency behaviors over the adolescent years, yet family engagement in community interventions was sporadic. In addition, while the Department received reports on the family circumstances, which included allegations of abuse and neglect, and investigated many of those concerns, there does not appear to have been a level of intervention necessary to impact the family functioning and child safety long-term.

The CIRT made several key observations regarding this case:

First, while the child and family had contact with multiple systems, including child welfare, juvenile justice, law enforcement and community mental health, cross-system collaboration by multiple system partners did not occur. Cross-system collaboration can be key to successful intervention for families with complex needs and may have

assisted this family in accessing appropriate prevention services while the child was a young adolescent.

Second, the CIRT identified an absence of adequate resources when the child left home. There is a critical need for more robust resources, especially in rural parts of the state, for older children and their families to seek respite (such as youth drop-in centers and youth shelters). Many children also benefit from a higher level of care, such as residential mental health or substance use treatment, which are often difficult to access without court intervention.

Third, the Department often gathered the minimum required information during CPS assessments, which reflected a focus on the reported incidents of abuse, rather than a comprehensive review of the family functioning which limits the ability to make an accurate child safety decision.

Finally, law enforcement had contact with the child on multiple occasions in the months leading up to the child's death, and in multiple instances the child was seen in the company of adult males. It is unclear what efforts law enforcement made to notify the child's parents and it does not appear the reports were cross reported to the Department when they located a child in different high-risk situations.

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 recommends further review of Child Welfare rules and procedures which impact direct service to teenagers and their families, regarding cross-system collaboration information sharing, and partnership for teens involved with Child Welfare or who have had repeated contact with Child Welfare. Child Welfare should explore how investing in unaccompanied youth services leads to better outcomes in youth, prevents future foster care placement, and encourages meaningful collaboration – both with youth and DHS, as well as between professional agencies. DHS, within Self Sufficiency and Child Welfare, begun workgroups earlier in 2020 to discuss gaps in services affecting missing, runaway, and homeless youth. The workgroups have been temporarily halted by COVID-19, but coordinators in the programs have continued efforts to evaluate policies and services available to families connected to the child welfare system. Expected to begin in Summer 2020, the Runaway and Homeless Youth (RHY) Program, which is a part of Self Sufficiency, is finalizing a third-party grant agreement for a statewide needs assessment of youth homelessness services and partnerships, and the provision of a roadmap for building an optional youth system in local areas. In addition, the RHY program intends to form a statewide homeless Youth Action Board that will amplify youth input by sharing their lived experience to impact

youth homelessness in their communities, and influence policy making and programming decisions on local and statewide issues.

The CIRT recommends further exploration and increased collaboration with law enforcement agencies across the state to better understand the expectations for response and cross-reporting when a child is located in high risk situations, and how the response differs if the child is or is not reported as a missing child. The Child Fatality Prevention and Review Program will begin exploratory work in June 2020 with law enforcement partners to better understand practices across the state when they encounter an adolescent in a high-risk situation. These conversations will guide further efforts to improve cross-reporting with law enforcement partners. The Child Fatality Prevention and Review Program has led the work and completed the new Mandatory Reporting Video which is expected to be distributed to the public in early June 2020.

Leadership at the local office involved in this case has committed to reviewing local CPS assessment practices to identify opportunities for improvement in comprehensive information gathering, accurate dispositions and complete documentation. In May 2020, a CPS Fidelity Review occurred on CPS assessment practice in both the local office and across the state. While results of this review are currently still being compiled, an action plan will be developed in partnership with the Child Safety Program and local leadership to address the CIRT findings as well as other case practice improvements identified in the CPS Fidelity Review beginning in June 2020.