Critical Incident Review Team Final Report

Oregon Department of Human Services
CHILD WELFARE

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 (ODHS). The reviews are called by the Department Director to quickly analyze ODHS actions in relation to the critical incident and to ensure the safety and well-being of all children within the custody of ODHS 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 the ODHS website.

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<tr><td colspan="3">CIRT ID: E0Q67W1VP5</td></tr>
<tr><td>Date of critical incident:
August 3, 2024</td><td colspan="2">Date Department became aware of the fatality:
August 3, 2024</td></tr>
<tr><td>Date Department caused an investigation to be made:
August 3, 2024</td><td colspan="2">Date of child protective services (CPS) assessment disposition:
September 13, 2024</td></tr>
<tr><td>Date CIRT assigned:
August 5, 2024</td><td colspan="2">Date Final Report submitted:
November 13, 2024</td></tr>
<tr><td>Date of CIRT meetings:

August 27, 2024
October 10, 2024
October 11, 2024</td><td>Number of participants:
13
31
26</td><td>Members of the public?
No
Yes
Yes</td></tr>
</table>

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

Date of report: August 3, 2024 **Assignment decision:** Assign (OTIS)	**Allegation(s):** Neglect	**Disposition(s):** Unfounded

On August 3, 2024, the Office of Trainings, Investigations, and Safety (OTIS) received information that the child, age 17, who was being supervised by Oregon Department of Human Services (ODHS) in a hotel, eloped from the hotel room and died by suicide. The child used a rope they had purchased and that had been confiscated a few days prior. Due to the third-party nature of the allegation of neglect, severity of the incident, and conflicting information as to how the rope was accessed, this was assigned for investigation by OTIS.

The child previously attempted suicide in April 2024. At that time, the child made statements this was not an attempt to die by suicide but was an impulsive act they thought would not result in harm. As a result of this incident, they were hospitalized briefly. While at the hospital they were diagnosed with Schizophreniform Disorder and prescribed Zyprexa (also known by the generic name Olanzapine), an anti-psychotic medication. Upon hospital discharge the child was recommended to engage in services and they returned to Temporary Lodging (TL), which is used when children and young adults are staying in a temporary setting/hotel with ODHS staff supervising due to no other options available.

Shortly after their hospital stay, the child stopped taking prescribed medication and the resulting decline in mental health was rapid and well documented. The child had auditory and visual hallucinations and was preoccupied with a belief that they had lived multiple lives. The child believed that they would move to the next life and unlock superpowers. The fantastical thinking and continual discussion on “moving to the next realm” caused great concern among those providing care for the child. Extensive

efforts were taken by clinical and non-clinical partners to address the child's declining mental health during this time.

On July 29, 2024, while on an outing with an adult, the child requested to go to a local outdoors-themed store. The child left the car while it was being parked, ran into the store before the adult could catch up, and purchased a rope. The child refused to return the rope or turn it over to the adult who consulted with the ODHS caseworker. The child initially said the rope was to secure a scooter; however, when confronted, acknowledged the rope was to end their life. The child explained this was not killing themself but taking off the mortal skin and moving onto the next realm.

The caseworker notified and engaged in safety planning with supervising professionals. The child gave staff the rope, which was secured in a staff room in the hotel. The child did not have access to this room when staying in TL and had never previously tried to enter the room. The caseworker consulted with involved parties including the Coordinated Care Organization (CCO) care coordinator, assigned mental health therapist, and ODHS supervisory staff. The mental health professional expressed concern about the child's increase in psychotic behaviors and suggested a return to an inpatient level of psychiatric care. It was determined that a referral from an emergency department (ED) assessment was required for admission, and either the community mental health authority or designee or law enforcement intervention and placement of a mental health hold would be required to force an ED assessment given the child's refusal to willingly participate.

Service providers were contacted and engaged in an onsite crisis evaluation at the TL location. The child initially refused to speak but then engaged. The child described a spiritual belief system that involved past lives and elevation to alternate spiritual planes consistent with previous psychiatric symptoms presentation. The child acknowledged they purchased the rope with the intention of using it to hang themselves but stated they had no plan to die by suicide imminently. The child explained they did not view dying by suicide in the generally accepted context but rather as a component of a spiritual belief system. The child denied plans to die by suicide in the near future. The child acknowledged they stopped

taking the psychiatric medication regimen and stated they did not have an interest in taking psychiatric medication in the future. Staff recommended the child engage in an assessment at the ED, which was declined. The child engaged in safety planning and contracting with staff, who recommended self-care, checking in with TL staff regularly, and follow up if needed. On July 30, 2024, the ODHS caseworker consulted with the child's legal counsel, who requested constant supervision. The child refused a scheduled doctor's appointment on this day due to concerns it was a veiled attempt to get an evaluation at the hospital.

On July 31, 2024, a treatment team meeting was held regarding the possibility of pursuing civil commitment. In addition, a TL staffing occurred resulting in a supervisory plan of 15-minute well-being checks. It was determined the situation necessitated an involuntary mental health hold at a hospital requiring LEA or Crisis Response determination or a voluntary presentation at the ED by the child. LEA was contacted and responded to the TL location. They were shown the rope and advised of the child's intention regarding the rope. The child denied experiencing suicidal ideation or having a plan and therefore did not meet criteria for an LEA hold. Crisis Response was contacted and responded; the child refused to speak with them, and no further involuntary action was deemed available. A follow up appointment with the assigned mental health provider was set up for the following day.

From July 31, 2024, through August 2, 2024, ODHS staff engaged in multiple conversations and meetings with community partners and legal representatives regarding the option of pursuing civil commitment. Due to the child's age, civil commitment, while not impossible, was somewhat unprecedented with careful planning necessary to proceed. It was noted that the child's symptom presentation, statements denying imminent or immediate risk to self, and lack of demonstration of imminent risk would be challenging to eligibility for civil commitment. Additionally, it was noted, even if legal criteria for a civil commitment were met, standard civil commitment proceedings for adults generally involve stabilization and placement at the Oregon State Hospital. Due to the child's age, the Oregon State Hospital would not be available without exception. No facilities were noted to exist in Oregon that could administer involuntary care and medication to a minor. On August 2, 2024, ODHS staff contacted the

Oregon State Hospital superintendent and left a message to consult regarding options should civil commitment efforts proceed.

Additionally on August 2, 2024, the option of placement at a crisis center was discussed with involved parties due to the lack of involuntary inpatient care available. While not able to enforce medications, there was consideration that it was a care setting with behavioral health staff on site. Upon consultation, the child's attorney expressed concern about a crisis center as a placement due to the general availability and use of physical restraints within the setting, while the program was a subacute psychiatric setting, the child's attorney did not agree it was a sufficient level of care to meet the child's needs and opposed the placement.

Additional challenges regarding secure transportation to the crisis center were noted, so ODHS initiated efforts to coordinate secure transportation if needed. Considering the multiple challenges and outstanding questions regarding the feasibility and resistance to the crisis center as an interim support, the decision was made to hold an Interdisciplinary Team Meeting with all involved partners on Monday, August 5, 2024, while maintaining high risk supervisory status in the TL placement. Additionally, continued consideration and navigation of potential civil commitment legal actions occurred.

During this time, support professionals forwarded text messages received from the child to ODHS outlining a plan by the child to give up all material possessions, quit work, and wait 10 months to leave the material world.

On August 3, 2024, shortly after 4 a.m. the child reportedly ran from the hotel room despite de-escalating efforts by the awake supervising staff. The child entered the staff room where a staff member was sleeping, grabbed the previously purchased rope from a closet, and left the hotel. The two TL workers ran after the child; both had shoes off, and no phones initially. One worker chased the child for an extended period of time, engaged in de-escalation interactions when contact could be made and then sustained injuries to both feet before losing sight of the child. The TL worker saw police and crisis response drive by several times, and they tried to flag them down, but they didn't see the worker. Emergency services were contacted to support efforts to locate the child. The other TL worker

drove around trying to find the child until they received notification from law enforcement that LEA had found the child deceased by suicide.

The OTIS investigator engaged in interviews with numerous ODHS Child Welfare staff tasked with supervising Temporary Lodging (TL), support professionals tasked with supervising the child in TL, Child Welfare staff assigned to provide case management and service coordination and the child's assigned attorney. In addition, the OTIS investigator observed the physical location of the TL accommodations, reviewed law enforcement reports and mental health crisis response records, and Child Welfare documentation related to TL supervision and tracking.

The interviewed witnesses and reviewed documentation were consistent regarding the efforts to address and maintain the child's safety prior to the critical incident. Due to consistent statements regarding these extensive efforts to ensure the child's physical and mental health needs were met, the allegations of neglect were determined to be unfounded.

Relevant prior Department reports under the following cases are detailed below in the following order:

- **Family Case**
- **Description of relevant prior Department reports under the case of resource parent #1**
- **Description of relevant prior Department reports under the case of resource parent #2**
- **Child Caring Agency #1 Case**
- **Child Caring Agency #2 Case**
- **Child Caring Agency #3 Case**
- **Child Caring Agency #4 Case**
- **Child Caring Agency #5 Case**

Description of relevant prior Department reports under the family case:

Date of report:	**Allegation(s):**	**Disposition(s):**
August 15, 2007	Threat of Harm by Unknown Perpetrator,	Unable to Determine (all)

Assignment decision: Within 24 hours	Threat of Harm by Unknown Perpetrator, Physical Abuse by Unknown Perpetrator, Physical Abuse by Unknown Perpetrator	

On August 15, 2007, ODHS received an allegation of threat of harm and physical abuse of the child, 2 months old, and the child's 2-year-old sibling, by their mother. It was reported the mother threatened to kill the children and herself if the father of the children left the home.

On August 17, 2007, the CPS worker attempted contact with the family. During the CPS assessment the CPS worker interviewed the mother and made collateral contacts. The CPS worker was unable to contact the father. It was learned there was a domestic dispute, the father moved out of the home, and the mother filed a restraining order. There was no information from the mother or service providers that the mother's mental health was impacting functioning. The CPS worker documented the mother may have cognitive delays, though further documented the delays didn't seem to interfere with parenting. Contact with other agencies confirmed mother had another child who lived with their father.

At the conclusion of the CPS assessment, ODHS determined the allegations of threat of harm and physical abuse of the child and the child's sibling by their mother were unable to be determined.

Date of report: October 5, 2007 **Assignment decision:** Close at Screening	**Allegation(s):** Neglect	**Disposition(s):** N/A

On October 5, 2007, ODHS received a report alleging the child, 3 months old, and the child's 2-year-old sibling were left in a car unsupervised by their mother. The mother explained this was learned by the maternal

grandmother having done this and there was no knowledge it was unsafe. A letter explaining supervision expectations was sent to the mother.

ODHS determined the report did not meet the criteria to assign for CPS assessment and it was closed at screening.

Date of report: February 22, 2008 **Assignment decision:** Within 24 hours	**Allegation(s):** Threat of Harm by Mother, Threat of Harm by Mother, Neglect by Mother, Neglect by Mother, Physical Abuse by Mother, Physical Abuse by Mother	**Disposition(s):** Unfounded (all)

On February 22, 2008, ODHS received a report alleging threat of harm, neglect, and physical abuse of the child, 8 months old, and the child's 3-year-old sibling, by their mother. It was reported the mother has been seen hitting the child's sibling in the head and has threatened to die by suicide.

On February 22, 2008, the CPS worker interviewed the mother who acknowledged being stressed as a single parent and denied hitting the deceased child's sibling except to spank on the bottom. During the CPS assessment, the CPS worker made collateral contacts. It was learned the mother was reported to be stressed and doesn't trust anyone. The mother was reported to be trying but there were concerns about parenting skills and ability to think things through.

At the conclusion of the CPS assessment, ODHS determined the allegations of threat of harm, neglect, and physical abuse of the deceased child and the deceased child's sibling by their mother were unfounded.

Date of report: March 10, 2008 **Assignment decision:** Closed at Screening	**Allegation(s):** Physical Abuse	**Disposition(s):** N/A

On March 10, 2008, ODHS received a report alleging the deceased child, 9 months old, and the deceased child's 3-year-old sibling were being hurt by their mother having used a "zapper" on the children. Law enforcement reportedly removed the "zapper" from the home two nights prior.

It was determined this report did not meet criteria for a CPS assessment.

Date of report: June 11, 2008 **Assignment decision:** Within 24 hours	**Allegation(s):** Threat of Harm by Unknown Perpetrator, Threat of Harm by Unknown Perpetrator, Physical Abuse by Unknown Perpetrator, Physical Abuse by Unknown Perpetrator	**Disposition(s):** Unable to Determine, Unable to Determine, Unfounded Unfounded

On June 11, 2008, ODHS received a report alleging threat of harm and physical abuse of the child, 1 year old, and the child's 3-year-old sibling, by an unknown perpetrator. The child's sibling was observed repeatedly slapping themself, falling to the floor, and then saying "mommy, daddy."

On June 12, 2008, the CPS worker attempted contact with the family and made contact on June 13, 2008. The CPS worker attempted to interview the child's sibling, documenting they had significant speech delays. During the CPS assessment, the CPS worker made collateral contacts.

The CPS worker learned the mother was the only adult living in the home. The mother's history of making bizarre statements and exhibiting poor judgment was documented.

At the conclusion of the CPS assessment, ODHS determined the allegations of threat of harm and physical abuse of the child and the child's sibling by an unknown perpetrator were unable to determine.

Date of report: September 23, 2008	**Allegation(s):** Threat of Harm by Unknown Perpetrator,	**Disposition(s):** Unfounded (all)

Assignment decision: Within 24 hours	Threat of Harm by Unknown Perpetrator, Physical Abuse by Unknown Perpetrator, Physical Abuse by Unknown Perpetrator	

On September 23, 2008, ODHS received a report alleging threat of harm and physical abuse of the child, 1 year old, and the child's 3-year-old sibling by their mother. Reportedly, the child's sibling had facial injuries caused by the mother.

On September 23, 2008, the CPS worker attempted contact with the family and made contact on September 24, 2008. The CPS worker observed both children and interviewed the child's sibling whose statements were difficult to understand. It was documented both children had bruising on their face.

During the CPS assessment, the CPS worker made collateral contacts. It was learned the mother was paranoid, and the CPS worker documented the mother demonstrated some emotional instability. The child's sibling's behavior was observed to be extremely challenging, including screaming, hitting, and biting. The mother did not have a support system, yet it was also learned the children's basic needs were met and all medical care needs were met. The CPS worker documented the mother, and the children were engaged in services in the community that were specific to the needs of the family. The CPS worker offered the mother cooperative services with Child Welfare that were declined.

At the conclusion of the CPS assessment, ODHS determined the allegations of threat of harm and physical abuse of the child and the child's sibling by their mother were unfounded.

Date of report: January 16, 2009 **Assignment decision:** Closed at Screening	**Allegation(s):** Sexual Abuse, Sexual Abuse	**Disposition(s):** N/A

On January 16, 2009, ODHS received a report of the child's 4-year-old sibling exhibiting sexualized behavior toward children and adults that was escalating. The child, age 1, and their mother resided in the home with the sibling, and it was reported the mother does not take the information seriously.

ODHS determined the report did not meet the criteria to assign for CPS assessment and it was closed at screening.

Date of report: February 24, 2009 **Assignment decision:** Within 24 hours	**Allegation(s):** Threat of Harm by Mother, Threat of Harm by Mother, Neglect by Mother, Neglect by Mother	**Disposition(s):** Founded (all)

On February 24, 2009, ODHS received a report of threat of harm and neglect of the child, age 1, and the child's 4-year-old sibling by their mother due to being left in a running car. Reportedly, the sibling exited the car without the mother's knowledge and ran toward a busy street when someone intervened. This was the second report of the mother leaving the children unattended in the car.

On February 24, 2009, the CPS worker attempted contact with the family and contact was made on February 26, 2009. The CPS worker interviewed the mother, witnesses, and collateral contacts. The mother stated an adult was present and in the car with the children. A phone number was provided for the adult and despite attempts, the CPS worker was unable to get a return call. The CPS worker documented another adult being there was unlikely since the incident was able to occur. It was learned from contacts made that for months the mother has had mood swings and odd behavior, the home was dirty, and the mother made statements such as strangers will take care of the children.

At the conclusion of the CPS assessment, ODHS determined the allegations of threat of harm and neglect of the child and the child's sibling were founded.

Date of report: September 29, 2009 **Assignment decision:** Within 24 hours	**Allegation(s):** Neglect	**Disposition(s):** Opened in error

On September 29, 2009, ODHS received a report of neglect of the child, age 2, and the child's 4year-old sibling, by their mother, due to a lack of supervision of the children. Reportedly, the child was observed running into traffic and the following day the sibling was observed home alone.

The CPS worker confirmed the reported issues were being addressed in an open CPS assessment.

ODHS determined the report was opened in error.

Date of report: December 3, 2009 **Assignment decision:** Within 24 hours	**Allegation(s):** Threat of Harm by Mother, Threat of Harm by Mother	**Disposition(s):** Founded (all)

On December 3, 2009, ODHS received a report alleging threat of harm of the child, age 2, and the child's 5-year-old sibling by their mother due to assaulting a man in the presence of the children. Also living in the home was the mother's live-in companion. At the time of this report, the case was opened and there was an in-home safety plan.

On December 4, 2009, the CPS worker contacted the family. During the CPS assessment, the CPS worker also contacted witnesses to the incident. It was learned that an incident of violence occurred where the mother assaulted the live-in companion with the children present.

At the conclusion of the CPS assessment, ODHS determined the allegations of threat of harm of the child and the child's sibling by their mother were founded.

Date of report: May 16, 2011 **Assignment decision:** Closed at Screening	**Allegation(s):** Threat of Harm, Threat of Harm	**Disposition(s):** N/A

On May 16, 2011, ODHS received a report of the mother's pregnancy due to concerns about capacity to safely parent. The child and sibling were in an out-of-home safety plan.

ODHS determined the report did not meet the criteria to assign for CPS assessment and it was closed at screening.

Date of report: January 4, 2012 **Assignment decision:** Within 24 hours	**Allegation(s):** Threat of Harm by Mother	**Disposition(s):** Unable to Determine

On January 4, 2012, ODHS received a report alleging threat of harm of the child's newborn sibling by their mother due to inability to parent other children who are not in her care.

On January 2, 2012, the CPS worker contacted the parents and on January 5, 2012, the CPS worker observed the newborn sibling. The CPS worker reviewed the mother's psychological evaluation, contacted service providers, and made in-home service referrals. It was learned the mother engaged in services and obtained safe housing with the father of the newborn sibling. The CPS worker documented the information did not demonstrate how past behavior was preventing the mother from parenting.

At the conclusion of the CPS assessment, ODHS determined the allegation of threat of harm of the child's newborn sibling by their mother was unable to determine.

Date of report: October 9, 2012	**Allegation(s):** Threat of Harm by Mother, Threat of	**Disposition(s):** Unable to Determine (all)

Assignment decision: Within 24 hours	Harm by Mother, Threat of Harm by Father, Threat of Harm by Stepfather	

On October 9, 2012, ODHS received a report alleging threat of harm to the child, age 5, and the child's 9-month-old younger sibling by their mother, and their stepfather and father respectively. Reportedly, the mother and stepfather/father had mental health issues, were verbally and physically abusive to one another in front of the children and were observed dragging the child by the arm. It was further reported that the morning of the report, the children were crying as they left with the mother yelling at the stepfather/father.

On October 10, 2012, the CPS worker contacted the family and interviewed the parents and the child. The parents admitted to arguing very loudly in front of the children and acknowledged it was a problem neighbors have seen and at times resulted in law enforcement being called. The CPS worker documented the parents have identified other ways to work through disagreements and are engaged in services. The child made no disclosures.

During the CPS assessment, the CPS worker reviewed the Child Welfare history, gathered and reviewed records, and contacted collaterals. It was learned the family was engaged in services.

At the conclusion of the CPS assessment, ODHS determined the allegations of threat of harm of the child and the child's younger sibling by their mother and father and stepfather respectively, were unable to determine.

Date of report:	**Allegation(s):**	**Disposition(s):**
June 6, 2013 **Assignment decision:** Within 24 hours	Physical Abuse by Unknown Perpetrator, Threat of Harm by Father, Threat of Harm by Stepfather	Unfounded (all)

On June 6, 2013, ODHS received a report alleging physical abuse of the child's 1-year-old younger sibling by an unknown perpetrator and threat of harm of the younger sibling and the 6-year-old child by their father and stepfather respectively. Reportedly, the younger sibling was observed with a suspicious quarter size bruise under the lip. It also was reported that the father/stepfather was out of control, destroying things in the home, resulting in the mother leaving with the children.

Child Welfare contacted the family on June 6, 2013. During the CPS assessment, the CPS worker also made collateral contacts.

The CPS worker interviewed the parents and the child and observed no bruising on the younger sibling. The parents acknowledged the out-of-control behavior being a response to feeling inadequate when the mother wanted to put the younger sibling in childcare. It was documented there was no information to support impacts of the family dynamics on the children.

At the conclusion of the CPS assessment, ODHS determined the allegation of physical abuse of the child's younger sibling by an unknown perpetrator and threat of harm of the younger sibling and the child by their father and stepfather respectively were unfounded.

Date of report: November 8, 2013 **Assignment decision:** Within 24 hours	**Allegation(s):** Threat of Harm by Father, Threat of Harm by Stepfather, Threat of Harm by Mother, Threat of Harm by Mother	**Disposition(s):** Founded (all)

On November 8, 2013, ODHS received a report alleging threat of harm of the child, age 6, and the child's 1-year-old sibling by their mother and stepfather and father respectively. Reportedly there was an incident where the father/stepfather assaulted the mother with the children in the home resulting in an arrest.

On November 8, 2013, Child Welfare contacted the family. During the CPS assessment, the CPS worker reviewed the relevant documentation. The CPS worker contacted the parents, the children, and collateral contacts.

It was learned this was not the first incident of violence. The stepfather/father stated mutual physical altercations have been occurring since prior to the child returning home. In the recent incident, the stepfather/father was charged with assault IV and strangulation and stated it was the mother's fault. The child witnessed the mother being punched in the stomach and pushed down the stairs landing on the child. The child and the younger sibling exhibited aggressive behaviors.

The CPS worker documented the mother's lack of engagement in services needed to safely parent.

At the conclusion of the CPS assessment, ODHS determined the allegations of threat of harm of the child and the child's younger sibling by their mother and stepfather and father respectively, were founded.

Date of report: November 14, 2014 **Assignment decision:** Within 5 days	**Allegation(s):** Physical Abuse by Stepfather, Threat of Harm by Father, Mental Injury by Stepfather, Threat of Harm by Father, Mental Injury by Mother, Neglect by Mother	**Disposition(s):** Founded Founded Unfounded Unfounded Unfounded Founded

On November 14, 2014, ODHS received a report alleging threat of harm of the child's 2-year-old younger sibling and physical abuse and mental injury of the child, age 7, by father and stepfather respectively. Also alleged is mental injury and neglect of the child by the mother. Reportedly, the child disclosed details of past incidents, such as their stepfather picking them up

by the feet and throwing them against a wall and picking them up by the neck until they fell asleep.

The CPS worker reviewed the history and other relevant documentation. During the CPS assessment, the CPS worker contacted the family and made collateral contacts.

On November 14, 2014, the CPS worker interviewed the child who did not disclose abuse; however, the child consistently reported the details reported at screening during a second interview and to multiple other people. Through interviews with the parents, it was learned the father/stepfather denied the allegations and the mother stated the father/stepfather, who had a history of violent behavior, used excessive discipline on the child and choked them.

At the conclusion of the CPS assessment, ODHS determined the allegation of threat of harm physical abuse of the child's younger sibling by their father was founded and the threat of harm mental injury allegation was unfounded.

The allegation of physical abuse of the child by their stepfather was founded, and the allegation of mental injury of the child by the stepfather and mother was unfounded. The allegation of neglect of the child by the mother was founded.

Date of report: June 11, 2015 **Assignment decision:** Closed at Screening	**Allegation(s):** Threat of Harm	**Disposition(s):** N/A

On June 11, 2015, ODHS received a report of the mother's pregnancy due to concerns related to an inability to safely parent other children who are out of her care. Reportedly the father of the unborn child was schizophrenic, hospitalized numerous times due to mental health related behaviors, and was convinced by the mother to stop therapy and stop taking medication.

ODHS determined the report did not meet the criteria to assign for CPS assessment and it was closed at screening.

Date of report: April 18, 2017 **Assignment decision:** Closed at Screening	**Allegation(s):** Physical Abuse	**Disposition(s):** N/A

On April 18, 2017, ODHS received a historical report of the child, age 9, being beat up by their stepfather.

ODHS determined the report did not meet the criteria to assign for CPS assessment and it was closed at screening.

Description of relevant prior Department reports under the case of resource parent #1:

Date of report: January 9, 2012 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect	**Disposition(s):** N/A

On January 9, 2012, ODHS received a report of neglect by the resource parent. The child's 7-year-old sibling was being physically and sexually aggressive with another child until the child, age 4, hit the sibling. The resource parents intervened and stated the sibling would not have unsupervised contact with this child as this was a pattern of behavior and the child was unsafe with the sibling. Both the sibling and the child reportedly made disclosures to their resource parent of sexual abuse by a child in a prior foster home, which was addressed in another CPS assessment.

ODHS determined the report did not meet the criteria to assign for CPS assessment and it was closed at screening.

Description of relevant prior Department reports under the case of resource parent #2:

Date of report: January 9, 2012	**Allegation(s):** Neglect	**Disposition(s):** Unable to Determine

Assignment decision: Within 24 hours		

On January 9, 2012, ODHS received a report alleging neglect of the child's 7-year-old sibling and the child, age 4, by a resource parent for not protecting them from sexual abuse by the resource parent's child who lived in the resource home. The children were not living in the resource home at the time of the report.

On January 12, 2012, the CPS worker interviewed the resource parents and the sibling. During the CPS assessment, additional interviews of the children took place, and the CPS worker contacted collaterals. The CPS worker documented the child alleged to have had sexual contact with the children denied any sexual contact and does not have a history of sexual behavior towards others. The sibling stated they only told the resource parent about feeling uncomfortable but did not disclose abuse.

At the conclusion of the CPS assessment, ODHS determined the allegations of neglect of the child's sibling and the child by the resource parent were unable to determine.

Description of relevant prior Department reports under the case of Child Caring Agency #1:

Date of report: November 29, 2017 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect	**Disposition(s):** N/A

On November 29, 2017, ODHS received a report, screened by the Office of Training, Investigation, and Safety (OTIS), the child, age 10, instigated a physical altercation with other children in the licensed child caring agency where they lived, resulting in an out-of-control situation. The OTIS screener documented the child was moved from the child caring agency and staff were responsive to the situation.

ODHS determined the report did not meet the criteria to assign for CPS assessment and it was closed at screening.

Description of relevant prior Department reports under the case of child caring agency #2:

Date of report: June 21, 2018 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect	**Disposition(s):** N/A

On June 21, 2018, ODHS received a report screened by the Office of Training, Investigation, and Safety (OTIS), of the child, age 11, being punched by another child in the licensed child caring agency where they lived. The OTIS screener documented the child having no injuries and staff being responsive to the situation.

ODHS determined the report did not meet the criteria to assign for CPS assessment and it was closed at screening.

Description of relevant prior Department reports under the case child caring agency #3:

Date of report: July 19, 2019 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect	**Disposition(s):** N/A

On August 16, 2019, ODHS received a report screened by the Office of Training, Investigation, and Safety (OTIS), of the child, age 12, being injured while skateboarding and staff from the licensed child caring agency, where the child lived, delaying medical treatment. The screener obtained email documentation of the insurance barriers that caused the delay. It was reported the child was seen at the hospital the same day the injury was sustained.

ODHS determined the report did not meet the criteria to assign for CPS assessment and it was closed at screening.

Date of report: August 16, 2019 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect, Neglect	**Disposition(s):** N/A

On July 19, 2019, ODHS received a report screened by the Office of Training, Investigation, and Safety (OTIS), of the child, age 12, hitting another child in the licensed child caring agency where they lived. The OTIS screener documented the child was taken to the hospital for medical attention and staff were responsive to the situation.

ODHS determined the report did not meet the criteria to assign for CPS assessment and it was closed at screening.

Description of relevant prior Department reports under the case of child caring agency #4:

Date of report: February 16, 2022 **Assignment decision:** Closed at Screening	**Allegation(s):** Neglect	**Disposition(s):** N/A

On February 16, 2022, ODHS received a report screened by the Office of Training, Investigation, and Safety (OTIS), of the child, age 14, and two other children, leaving the licensed child caring agency where they were living without authorization and staff did not prevent them from leaving. The OTIS screener determined it was not a locked facility and children may leave. Reportedly while away, there was sexual abuse that occurred. The sexual abuse allegations were assessed by Child Welfare and both allegations were determined to be founded for sexual abuse by the child.

ODHS determined the report did not meet the criteria to assign for CPS assessment and it was closed at screening.

Date of report: August 24, 2022 **Assignment decision:** Closed at Screening	**Allegation(s):** N/A	**Disposition(s):** N/A

On August 24, 2022, ODHS received a report screened by the Office of Training, Investigation, and Safety (OTIS), of the child, age 15, engaging in a physical altercation with another child in the licensed child caring agency where they lived. The screener documented the steps taken by staff and determined staff were responsive to the situation, although one staff person who intervened had an expired Crisis Prevention Institute certification.

ODHS determined the report did not meet the criteria to assign for CPS assessment and it was closed at screening.

Description of relevant prior Department reports under the case of child caring agency #5:

Date of report: April 19, 2022 **Assignment decision:** Within 24 hours	**Allegation(s):** Wrongful Restraint	**Disposition(s):** Unsubstantiated

On April 19, 2022, ODHS received a report screened by the Office of Training, Investigation, and Safety (OTIS), of wrongful restraint of the child, age 14, by staff in the licensed child caring agency where they lived. Reportedly the child disclosed they were put into a restraint by staff after asking to call their attorney and during the restraint, the child was unable to breathe and experienced pain.

On April 20, 2022, the OTIS investigator reviewed all documents relevant to the incident, the video footage of the incident and interviewed the child, staff, and collateral contacts involved. The OTIS investigator documented observing the child to be physically aggressive with staff in a manner that warranted a physical intervention for the safety of the child and others. The

injuries which were described as soreness to the forearms and some petechiae on the shoulders, were consistent with the amount of struggle described and were not present when the child was interviewed 24 hours following the restraint.

At the conclusion of OTIS investigation, ODHS determined the allegation of wrongful restraint of the child was unsubstantiated.

Date of report: August 15, 2022 **Assignment decision:** Within 24 hours	**Allegation(s):** Involuntary Seclusion	**Disposition(s):** Unable to Determine

On August 15, 2022, ODHS received a report screened by the Office of Training, Investigation, and Safety (OTIS), of involuntary seclusion of the child, age 15, by staff at a licensed child caring agency following an incident where the child reportedly became physically aggressive with staff and was placed in a restraint. Following the physical intervention, the child was taken to an isolation room for 20 minutes where they committed to safe behaviors and removed any potentially dangerous items from their person. The reporter expressed concern because the child was being safe and complying during this time, therefore should not have been confined alone in a room. Reportedly, there was a pattern of being placed in an isolation room without cause and in this incident the child was unwilling to get up from the couch.

On August 17, 2022, the OTIS investigator reviewed incident reports and interviewed the child, staff, and collateral contacts. The OTIS investigator documented the child was confined to a room alone for 20 minutes while they were required to process the incident with staff before leaving, the door was always unlocked. It was learned that it was standard practice for youth involved in physical interventions to be taken to the isolation room afterward. The isolation room was described by staff as a voluntary placement, where the child can leave freely and if they choose to leave, staff will verbally intervene to provide supervision and ensure the child continues to exhibit safe behaviors. The child caring agency indicated

adaptations to their policy were in process to reflect the youth's ability to voluntarily exit.

At the conclusion of OTIS investigation, ODHS determined the allegation of involuntary seclusion of the child was inconclusive.

Date of report: September 19, 2022 **Assignment decision:** Closed at Screening	**Allegation(s):** N/A	**Disposition(s):** N/A

On September 19, 2022, ODHS received a report screened by the Office of Training, Investigation, and Safety (OTIS), of the child, age 15, engaging in a physical altercation with another child in the licensed child caring agency where they lived. Reportedly both children sustained injuries, the child required medical attention, and the incident was reported to law enforcement. The delay in seeking medical attention was considered and determined it did not result in severe harm and was a training issue.

ODHS determined the report did not meet the criteria to assign for CPS assessment and it was closed at screening.

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 acknowledges the efforts of the involved ODHS and Oregon Health Authority (OHA) professionals to access necessary and appropriate care for the involved child within the complexities and barriers evident in the Child and Youth Behavioral Health System. The CIRT found no specific actions or inactions by ODHS Child Welfare or Law Enforcement that led to the critical incident.

The CIRT emphasized the need for a multi-system collaborative approach to support children and young people with complex needs in achieving permanency earlier. The CIRT noted that the child had numerous out-of-home placements throughout their lifetime due to significant mental and behavioral health issues, exacerbated by a lack of suitable care options.

While not proximal to the critical incident, the CIRT identified general practice areas for improvement within Child Welfare related to serving families with complex mental health needs and achieving timely permanency.

The CIRT recognizes that Temporary Lodging (TL) in Oregon should be discontinued for children and young adults with complex needs who require stable therapeutic placements. However, until the broader behavioral health system has capacity and can adequately support these needs, enhancements to training and support for staff supervising children in TL may be beneficial. The CIRT acknowledges the unnecessary burden of complex system navigation and expertise expectations on the Child Welfare workforce.

In the weeks leading up to the critical incident, the child experienced worsening symptoms of severe and persistent mental illness that remained largely untreated at the child's request. This situation revealed gaps in Oregon's legal framework regarding involuntary care for minors evidencing imminent risk of harm to self and others. The CIRT also identified challenges experienced in this case are demonstrative of the pervasive lack of clarity, complexity, bias, and practice drift existent in the current child and youth-serving behavioral health systems.

The CIRT acknowledged that conflict and disagreements between ODHS and legal partners can hinder effective supportive services for a child.

Lastly, the CIRT recognized the intricate challenges within Oregon's Child and Youth Behavioral Health Service system and stress the need for urgent prioritization of the more than 200 previously identified recommendations for improvement dating back to 2018. Identified improvements generally consist of themes related to Service Array, Coordination of Care, Consent, Funding, and Capacity, all currently within various stages of evaluation, development, or implementation.

The findings and recommendations from this CIRT are being forwarded to the Governor's Behavioral Health Initiative – Sub Cabinet focused on Child Welfare and Youth Behavioral Health. This group started in September 2024, convening Oregon Department of Human Services, Oregon Health Authority and Governor's Office leaders to develop an action plan to improve outcomes for children served across child welfare, youth

behavioral health, public health, and Medicaid. The Sub Cabinet plans to present an action plan to Governor Kotek in mid-December.

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:

Child Welfare Recommendations:

- ODHS will develop enhanced training requirements for all ODHS staff who supervise children in TL either prior to supervising TL or within a designated time frame of TL. Examples include suicide prevention training such as QPR (Question, Persuade Refer), YouthSAVE, ASIST (Applied Suicide Intervention Skills Training), or CALM (Counseling on Access to Lethal Means), Mental Health First Aid for Adolescents or general Mental Health First Aid, and Collaborative Problem Solving. Child Fatality Prevention and Review Program, Equity, Workforce, and Training Development Team and Resource Management Team will evaluate current training requirements for TL supervising staff and develop this enhanced training plan that will provide applicable skills and knowledge to benefit staff supporting highly complex behaviors and needs of children in TL. These trainings do not supersede the need for ongoing clinical support from external partners. The enhanced training plan will be developed no later than January 31, 2025.

- Child Welfare will assess current access to subject matter experts (SMEs) and the barriers faced by staff, aiming to establish clear workflows for engaging both internal and external SMEs in complex behavioral health case planning. Child Safety, Child Fatality Prevention & Review Program (CFPRP), Treatment Services, Permanency, and Temporary Lodging Resource Management will develop specific guidelines for when to consult SMEs and outline processes for doing so. Recommendation will be completed no later than April 1, 2025.

- Permanency Program will lead efforts to ensure consistency in the use of the 90-day Staffing Supervising Guide[1] with the goal of improving parent engagement, providing culturally responsive services, timely concurrent planning and relative search and engagement. A plan to determine baseline data and identified measures for improvement will be developed and implemented no later than May 1, 2025.

- In the Special Masters Report on Temporary Lodging (TL), Recommendation #13 outlines options for staffing of Transition Homes for children in the TL pipeline. The CIRT supports that recommendation, as well as others already in place related to TL alternatives with therapeutic staffing such as Recommendation #4 outlining 1 and 2 child staffed homes. It is also recommended that CW continue current efforts to support up to seven such settings in Oregon through currently active RFA 5-10000-00008917. Child Welfare's Treatment Services Program will support and complete these efforts throughout 2025.

- Child Welfare staff require reliable points of contact with local community partners, expertise in navigating the behavioral health system, and collaboration with both internal and external programs to ensure effective care for children and young adults with complex needs, while minimizing the burden on staff. The Treatment Services Team, in partnership with local district leadership and the CFPRP's Behavioral Health Coordinator, will evaluate existing consultant supports and identify any gaps or new strategies to assist staff in navigating the local behavioral health system. The evaluation and development of strategies will be completed no later than June 2025.

***Additional Recommendations:**

The following recommendations involve broader child- and family-serving systems outside of ODHS Child Welfare. As such, timelines and specific strategies for completion are outside of the scope of the CIRT. The CIRT

[1] Child Welfare Procedure Manual

Chapter 4, Appendix 4.12: 90 Day Staffing Supervisor Guide Pages 727-729

does strongly encourage consideration of the following recommendations by the appropriate system partners.

- OHA to continue current efforts related to interpretation and application of Oregon Parental Rights and Minor Consent to Treatment statutes and Oregon administrative rules (OARs) with specific focus on avenues for treatment and care provision when consent is not required or provided by a minor. Upon completion of OHA efforts, OHA, System of Care Advisory Council, Child Welfare Safety & Permanency, Treatment Services, and Child Fatality Prevention and Review Programs will collaborate to develop workflows for wide distribution to workforce and partners on consent information and materials including clear statutory language, OARs, and guidance on the following:

    - Existing laws and authorities related to minor consent to care and parental rights.
    - Designated mental health authorities for crisis intervention including crisis mental health holds and transport.
    - Levels of behavioral health care with related consent parameters.
    - Physical restraint of individuals in danger of harm to self and/or others.
    - Workflows for escalation of service coordination for highly complex or critically in need children and young adults.
    - Avenues for involuntary transportation for assessment/evaluation and/or treatment for children or young adults at imminent risk of harm.

- Statute change regarding parental consent clarification and involuntary care for minors at imminent risk of harm to self or others using examples from other states, particularly Washington and California. In addition, accompanying development and inclusion of inpatient provider network authorized to provide involuntary care to minors.

- Legislative approval and funding for a position of Psychiatric Medical Director within ODHS to support Child Welfare in serving children and young people with complex behavioral needs.

- Provide theoretical and applied behavioral health training for judges, lawyers, and other legal partners working with youth in the Child Welfare system to enhance their understanding of the needs of children and families they serve. These representatives should also be involved in relevant system improvement projects to enhance collaboration and accountability in efforts to improve the system.

- Child and family-serving system partners engage in self-assessment to identify and address bias within their respective systems that may impact collaboration with other partners. Specifically, partners are asked to determine if bias related to perception of authority, knowledge base, and capacity/capacity-building of ODHS Child Welfare are impacting collaboration with Child Welfare workforce and if so, develop internal plans for reducing/eliminating identified bias.

- Creation of mechanism for dispute resolution and decision making when system partner disagreement impacts case planning for CW-involved children or young adults. Recommendation includes the identification or development of a dispute resolution or mediation-skilled neutral third-party entity made up of more than one subject matter expert with background in both behavioral health and child welfare practice, to expeditiously review, mediate, and make recommendation to legal bodies regarding best course of care.

- Collect feedback from direct support professionals such as Qualified Mental Health Associates (QMHAs), Qualified Mental Health Professionals (QMHPs), hospital Licensed Clinical Social Workers (LCSWs), and county Pre-Commitment Investigators to better understand where actual practices diverge from procedures, policies, or laws. The CIRT emphasizes the importance of collecting information directly from the workforce engaged in the complex behavioral health system to accurately identify areas needing improvement.

- Oregon Health Authority, in its continued contract development and oversight of Oregon CCOs, require and manage increased quality of care provision in addition to increased quantitative service array measures for providers. Additional measures could include but not be limited to:

  - Create alternative payment methodologies and enhanced pay structures for specialty services;
  - Development of alternative funding methodologies focused on service outcomes;
  - Implement additional treatment modalities beyond what currently exists.

- Particular attention and implementation of existing recommendations related to:

  - Creation of a single youth serving CCO structure to support consistent service access for children and young people statewide;
  - Enhancement of intensive community-based services available to support higher level needs outside of minimally available acute and subacute care settings.

- Expansion and broader availability of Supported Employment Programs to youth ages 16-18 under the Individual Support Plan (ISP) model currently in place in Oregon.

- Increase investment in “bridge” programs beyond Mobile Response and Stabilization Services (MRSS) for children and young adults transitioning between levels of care utilizing capitated funding for programs to provide case managers and/or skills trainers in community mental health programs to be assigned to youth in higher levels of care prior to discharge. Bridge resource to remain in place as transitional support until child or young person firmly established in intensive or general outpatient programs so that connection is not lost, and engagement can be increased.

- Careful reconsideration with rigid standards for eligibility and oversight for placement of young people in out-of-state, clinically justified treatment resources. Currently, privately insured and OHP non-CW-involved young people are eligible for out-of-state resource placement within current CCO care coordination and contracting standards. The rigid restriction for CW-involved young people exacerbates existing disadvantages and care disparity of vulnerable

populations. Inclusion of strong CCO vetting, care planning, an oversight review team of SMEs and rigid standards for contact and oversight could mitigate previous challenges in out-of-state treatment settings.

- To support quality control and management, the CIRT advocates for the expeditious implementation of the Oregon Ombuds Program 2023 2nd Quarter Report recommendation for the creation of an independent Office of the Ombuds for Children and Youth. The CIRT advocates that any new or existing Ombuds Program be available to community partners to provide feedback in addition to Oregon Health Plan members.