

# Children: Timing is critical for wrongful death lawsuits

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That previous limit is likely why state officials maintain they weren't required to examine the strangling death of 12-year-old Caden Berry in January 2017. His older brother tried to report the abuse he said they both endured to child welfare workers in 2016, but nothing was done. Their mother now faces charges of aggravated murder, murder by abuse and criminal mistreatment.

State officials did issue a truncated preliminary review of Berry's death in July 2017, but they called their decision to do so "discretionary." They stripped it of any information about department missteps, writing, "Due to the ongoing criminal investigation, this report does not include any department history regarding this family."

A leading child welfare advocate, Gelsner backed the changes to the fatality review process last year that expanded the scope of reviews. When the state's child protection system breaks down, officials owe it to child victims to see what can be learned, Gelsner said. The process, she said, is not about blaming any state worker or workers, but about improving outcomes for children.

"The intention is supposed to be that it's open and transparent, consistent with the law." That's not what happened.

## Incomplete picture

The Department of Human Services did not disclose its review of Secord's death until Nov. 5. His family had mourned him for 648 days. The report it published runs just two pages. An internal case review obtained by The Oregonian is 13.

The department concluded in its public report that none of its actions or inactions directly led to his death. The report says the agency received seven reports involving his safety between 2012 and 2017.

The longer internal report, however, says case workers did not adequately assess Secord's well-being during prior investigations. The document lists, case by case, the four times that Secord came to the attention of child welfare workers between 2012 and 2017. (The other three reports were made following his death.) Case workers did not substantiate allegations of neglect or abuse by the parents in any of those instances.

In the internal report, the reviewer concluded that the child welfare worker who took the report that he'd been hospitalized in August 2016 should have talked to other people both inside and outside of Secord's family before deciding not to investigate. His blood alcohol level was .408, five times the legal limit for an adult.

Until contacted by a reporter last week, McKune did not know case workers were alerted to her grandson's hospitalization. Secord and his family lived near her in Warrenton, and she was especially close to him and his sib-

lings. Had someone told her they were looking into how he had obtained the alcohol, she would have said, "Please and thank you."

"If they knew, they should have said, 'We've got to get to the bottom of this, because this isn't OK,'" she said.

She began her own calls to police and a child welfare hotline. She wanted someone to act on her reports about the man she believed was providing her grandson alcohol. Child welfare workers who took her calls sometimes told her they would pass her report along to a case worker to investigate, she said, but she never heard anything more.

After Secord died, she said, a case worker told her there was no record of her calls.

Secord stopped by her house two days before he died. She chided him for not being at school. He said he was on his way but wanted to tell her he had bought something to eat and drink for a man who had nothing. Secord said he walked with him to a store to buy him something with the \$11.96 he had.

"That was the kind of boy he was," McKune said.

She sometimes wears a sweatshirt with his face on it, and people stop her to share stories. One girl said he did not know her but stopped to help her when he saw her struggling with two men as he rode by on his skateboard.

"I said, 'Well that's our boy,'" his grandmother said.

It's not clear why all the information in Secord's case file review was not published in the public report. Oregon law requires the department to publish the findings of the fatality review panels.

Although child abuse reports are confidential in most cases, they are not after the child dies. Oregon law mandates records regarding the death be made public if a child died or suffered a serious injury as a result of abuse.

For Secord's birthday this year, his grandmother tied balloons to the red memorial she built for him in her front yard. She didn't know a report involving his death was ever released.

"He just had the world at his feet," she said. "How quick it can all stop."

## Misleading the public

Other states' child protection agencies act with much greater speed and transparency after a child's death. Colorado publishes nearly instant updates to its online database. Nevada must disclose case information within 48 hours after a child dies. Arizona publishes both initial and final reports following a child's death.

Oregon is required to keep the public informed about what's going on by posting regular updates. But it has not done so at times in the past and has failed to do so at all in the past year and a half.

The Oregonian obtained an internal agency review of the April 2017 death of a Lane County teenager. He died by suicide five months after child welfare workers checked reports that he was suicidal and had been physically abused by

his father.

To this day, the department has said nothing about the boy's death.

Gelsner, who tracks the fatality reviews, said she has asked the department several questions about reports that appear to be delayed or missing. She was told that clerical errors contributed to the delays.

Five of the six fatality reports the state has issued this year mislead the public about their timeliness, as they are dated earlier than they were released. The most recent report, regarding the death of two sisters in a fire in Eastern Oregon, is dated in bold letters Oct. 18. It first appeared on the state's website Nov. 15, four full weeks later. It was posted one day after The Oregonian asked the department why it was failing to comply with the reporting law.

McGinnis, the department spokeswoman, said the agency dates the documents when they are submitted for approval, not when they are made public.

The department issued a report about a Roseburg baby's spring 2017 death on Aug. 7 of this year. It's dated June 26.

The agency completed a nine-page internal review into the baby's death Sept. 29, 2017. That document, never made public but obtained by The Oregonian, details three interactions with infant's family that were not disclosed in the public report.

Under Oregon law, the fatality review team must request an extension if its members are not finished with their report within the required 70 days and each 30 days thereafter. Paksresht, the agency's director, must weigh the request and decide if the delay is acceptable.

He can take into account whether publishing a report may compromise a criminal investigation.

The department has only published one report this year regarding a child whose death led to criminal charges. The man who supplied Secord alcohol the day he died was sentenced in June to 10 days in jail. It was the same man his grandmother tried for months to report, McKune said.

The department has publicly acknowledged its child death reports are late in just one instance: a fatality report published Nov. 6. It cites staff changes and the 2017 changes in state law as reasons for the delay.

Internal emails submitted as court evidence eight days ago highlight the defensiveness behind some fatality reviews. In one message, Yamhill County supervisor Stacey Daeschner defended her employees' decision not to rule that the May 2016 co-sleeping death of Nevaeh Ellis was the result of neglect. She explained no one had told Ellis' mother, who had an extensive history of risky behavior around her children, that co-sleeping was dangerous.

When a superior asked Daeschner to explain her reasoning, she forwarded the message to a colleague and added, "this makes me want to throat punch her."

Daeschner said during a deposition in May

that a fatality review was a negative experience for her and her employees. "There is a process where you go through a file review and the consultant really picks apart all of the errors you made in the case," she said under oath.

She is named, along with the Department of Human Services, in a wrongful death lawsuit seeking \$3 million for Ellis' survivors.

## Costly cases

Timing is critical for wrongful death lawsuits. Families must provide official notice, called a tort claim, that they plan to sue the state for alleged negligence within one year after a child dies.

At a March 2017 legislative hearing, Gelsner acknowledged that the specter of civil litigation factored into the requests to change the fatality review laws. The state does not want "reports to be used in a tort claim where you just go hand it over and say, 'Here's my case,'" she said. Stacey Ayers, who led the state's child abuse investigation unit at the time, agreed.

The state has paid nearly \$1.5 million since 2016 to settle wrongful death claims brought by the families of two toddlers whose deaths were reviewed in the fatality reports. It is about to pay \$1.1 million more, pending a judge's approval, that will go to the siblings and attorney of Berry, the Keizer boy who was strangled to death.

"There is a significant question whether the state has relied for years on these cases falling through the cracks and enjoying the benefit of not having to pay for their negligence as a result," said David Kramer, a Salem attorney representing the estate. He confirmed the tentative terms of settlement to The Oregonian.

The state's lawyers are fighting four ongoing wrongful death lawsuits, including one filed on behalf of Ellis' survivors and a second suit filed on behalf of the family of Gloria Joya, a teenager who died in foster care from an untreated health condition.

Their deaths, in 2016, are the most recent chronicled by fatality reviews that include detailed timelines of the state's case histories with their families. All of the subsequent reports provide much less information.

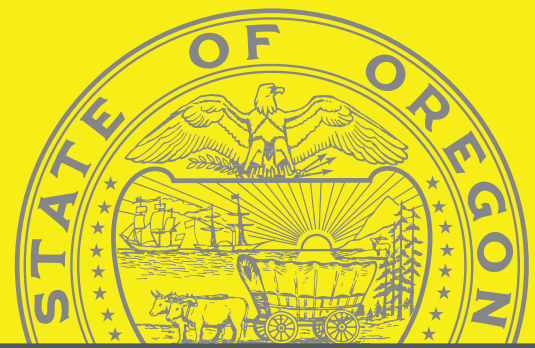
Wrongful death lawsuits can crawl through the court system for years. The state agreed to pay \$750,000 to survivors of Coltin Salsbury, who was killed in March 2014 by his mother's boyfriend as case workers were investigating whether or not he was being abused. The case wasn't settled until August 2016.

At least two more mothers have given notice that they may sue the state for allegedly causing the deaths of their boys in separate foster homes. One of the boys, Nicholas Lowe, died in a fire with his four foster siblings and their biological mother in March 2017. His mother contends the state's decision to place him in a "dangerous home" caused his death.

The Department of Human Services has never publicly acknowledged that Lowe died in the state's care.

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