

# **CRITICAL INCIDENT RESPONSE TEAM FINAL REPORT S.H.**

**January 4, 2011**

## **Executive Summary**

On September 11, 2010, 16-month-old S.H. died from what authorities have determined was an overdose of Benadryl. The Oregon Department of Human Services (DHS) had received referrals on the family prior to the report about the fatal incident. This is the final report of the S.H. CIRT.

CIRT members identified the following issues:

- Child welfare workers need additional training and may need different approaches in policy/practice to appropriately identify and respond to the root cause of neglect and effectively intervene before the issue becomes chronic;
- Child welfare workers need additional tools to assess and appropriately address safety concerns in cases involving the children of parents with developmental disabilities; and

To address these issues, the CIRT members recommend the following actions be taken:

- The Department should consult with state and national experts to create an inventory of best practices for assessing neglect cases. The Department should use that information to evaluate whether any changes to Oregon's assessment process, policy and/or practice need to be made to improve the response to neglect cases, especially cases of chronic neglect.
- Based on the findings above, the Department should develop specific training for caseworkers and supervisors focusing on best practices when assessing and responding to neglect cases.
- The DHS offices of Children, Adults and Families and Seniors and People with Disabilities should collaborate to identify expertise and resources from around the state that will assist child welfare to develop the tools and resources needed to assess the parenting skills and capacity of parents with cognitive and/or developmental disabilities.

The CIRT team also identified an overarching policy issue that merits additional discussion. Child Welfare services are intended to be temporary, short-term interventions to support a family's ability to safely parent their child/children. Recognizing that out-of-home placement is traumatic for families and often leads to poor outcomes for children, Oregon has been working to implement strategies that will safely and equitably reduce the use of foster care. However, in some cases involving parents who are developmentally disabled, those parents may not cognitively be able to develop the skills necessary to independently and safely parent their children without ongoing, long-term supportive services.

The overarching policy issue is how child welfare can adequately and appropriately interface with parents who have developmental/cognitive delays.

### **Summary of Reported Incident**

On September 11, 2010, an on-call worker was notified by police that 16-month-old S.H. was transported to the hospital after overdosing on Benadryl. Efforts to resuscitate S.H. were unsuccessful.

On September 14, 2010, DHS Director Dr. Bruce Goldberg determined that a CIRT be convened.

### **Background**

Prior to the child's fatality, the Department received a total of five CPS reports on the family: one in 2009 and four in 2010. Four of the reports were referred for assessment (referred to in this CIRT document as Referral 001, Referral 002, etc.), and one was "Closed at Screening." A Closed at Screening disposition is used when the information reported describes family conditions, behaviors or circumstances that pose a risk to a child but does not meet the definition of child abuse as defined in the Oregon Revised Statutes. For purposes of this CIRT document, that report will be identified as Closed at Screening 001.

### **Closed at Screening 001: 9/21/2009, Allegations: Neglect and Threat of Harm.**

It was reported that the home had dirt and filth everywhere. It was reported that the mother was bipolar and had attempted suicide in the past. The reporter indicated the parents have no patience with S.H., and the father tells the child to "shut up" when he cries. The report also stated the father was a registered sex offender with an IQ low enough to make him unable to complete treatment. The screener made a collateral contact to a previous caseworker who reported these concerns had been addressed in the past. The screening report also referred to a polygraph and risk

assessment which determined the father as being a low risk to sexually offend his own children. The report was then closed at screening.

The file review conducted as a result of this CIRT identified a polygraph report conducted in December of 2008, which indicated the father was terminated from sexual offender treatment on 11/07/00 for failure to comply with treatment. The polygraph report also identified additional at-risk behaviors on the part of the father, such as sexual relationships with minors. The risk assessment mentioned in the screening report was not located during the file review. Based on the information provided to the screener about the condition of the home, the mother's mental health issues, the parent's treatment of the child, and the father's unresolved sexual offending issues, the CIRT team concluded that this referral should have been assigned for field assessment.

**Referral 001: 2/22/2010, Allegation: Neglect. Disposition: Unfounded.**

Concerns were reported for nine-month-old, S.H. The caller had been in the home, and reported there was a hole from the outside of the home into S.H.'s room that mice entered through. The referral source also reported dirty clothes piled up, the sink and stove were full of dirty dishes and the floor covered with garbage and dirty diapers. S.H. was reported to be crawling and close to walking. The referral was assigned as an Immediate (within 24 hour) response. This was the appropriate screening disposition.

The worker went to the home and observed garbage and debris around the property. The worker noted concerns with both parents' mental health and cognitive issues; however, the worker also stated there was no clear presentation that the cognitive issues are impacting their ability to meet the child's needs. The assessment was closed as Unfounded for Neglect on 06/03/10.

There is minimal information documented that a comprehensive assessment was completed on this report of neglect. From the information that was documented, particularly relating to the condition of the home, the vulnerability of the infant child and the observation that the parents suffered from cognitive delays, there were safety concerns present. The CIRT team concluded that his referral should have resulted in a founded disposition for neglect.

**Referral 002: 5/19/2010, Allegations: Neglect, Threat of Harm. Disposition:**

**Unable to Determine.** Concerns were reported regarding one-year-old S.H and three-week-old L.H. According to the caller, the father was referred by his primary care doctor for a mental health evaluation with concerns he may be bipolar,

due to irritability and the fact that he disclosed punching walls in the presence of S.H. The report indicated the father was currently living alone and was the primary caretaker for the children during his weekend visits. The caller indicated the father had been diagnosed with alcohol abuse and borderline intellectual functioning. The referral was assigned as an Immediate (within 24 hour) response. This was an appropriate screening disposition.

The worker spoke by phone to both the parents (separate phone calls), and both agreed that dad would not be the primary caretaker or have visits until more information could be gathered from a mental health counselor. After that, the worker made contact with a mental health counselor who told the worker that dad could not receive services due to his cognitive limitations. The counselor indicated that because of those limitations they were unsure of the most effective way to offer treatment.

Subsequently, the worker made contact with the family regarding the father's temper. In addition, the worker also documented concerns about the condition of the home deteriorating but did not see that it had risen to the level where it impacted the children's safety. The worker made attempts to connect the parents to services through the local mental health agency, but the agency said the parents did not qualify for those services.

*During the course of this assessment, a new referral to the child abuse hotline was made on 08/04/10. Because the referral was made during an open assessment, the information was incorporated into the current open assessment.*

In Referral 003, concerns were reported regarding one-year-old S.H. and three-month-old L.H. The caller reported that the home was filthy, mice were again an issue and the home had a horrible smell. Caller also reported the father was a registered sex offender, and mother had disclosed she is bipolar and not currently taking her medication. Caller reported that the mother often talked about killing herself and would often call the father to come home because the children were driving her crazy. She had stated that she was afraid she was going to kill them.

Following receipt of this additional information, the worker did a follow-up with the mother about not taking her medication. The mother reported having an appointment coming up with her physician to address the issue.

The referral (combined Referrals 002 and 003) was coded as Unable to Determine. The worker cited that the home's condition continued to vary between dirty to

clean between home visits; however, the parents were able to demonstrate the ability to clean their home to an acceptable level each time they were instructed to do so. The worker, in staffing this case with the supervisor, described the children as clean and well-cared for and determined that there were no safety threats.

The CIRT team concluded that this referral should have resulted in a founded disposition for Neglect due to continued deterioration in the home, the severity of the condition of the home, the developmental stage of the children (crawling) and the threat of harm created by mother's unresolved mental health issues. The team also concluded that there was inadequate information in the assessment for the CIRT team to evaluate the issue of whether a finding of Threat of Harm, Sex Abuse was present due to the father's unresolved sexual offending issues and a lack of information regarding his risk to young children.

**Referral 003: 8/4/2010, Allegation: Neglect, Threat of Harm. Disposition: Closed.** Because there was an open assessment when this call was received, the issues were addressed in the then-open assessment (Referral 002). This is the appropriate disposition and is in compliance with department policy and rules.

**Referral 004: 9/11/2010, Allegation: Neglect, Disposition: Founded**  
It was reported while the father had been caretaking S.H. while the mother and L.H. were out with the maternal grandmother. The father was outside smoking a cigarette, and S.H. was inside the home. When the father went back inside, he found S.H. on the floor. According to reports, S.H. had ingested approximately forty to fifty tablets of generic Benadryl. S.H. was taken by ambulance to the hospital, where he later died.

Upon investigation, DHS workers found the home to be unsafe for children of this age due to unsanitary conditions, multiple small items on floor on which a child could choke, and unsecured medication bottles. The CIRT team concluded that is was the appropriate disposition.

## **Issues and Recommendations**

The CIRT team identified the following systemic issues and recommendations in this case:

**Issue #1: Child welfare workers need additional training and may need different approaches in policy and practice to appropriately respond to the “root cause” of neglect and then to effectively intervene in neglect cases before they become chronic.**

In this case, the issue that was the primary focus of both workers and supervisors was the condition of the home. Because the parents were able to clean the home in response to feedback about its poor condition, staff concluded that no immediate safety threats were present. It does not appear in this case that workers and supervisors considered the primary cause for the varying conditions found in the home. In the view of the CIRT members, there was sufficient information in the file to determine that the parents struggled cognitively to understand that the condition of their home could result in an immediate safety risk to their child.

Neglect, as defined in OAR 413-015-1000, includes failure, through action or omission, to provide and maintain adequate food, clothing, shelter, medical care, supervision, protection, or nurturing. This case presented at least two types of neglect: physical neglect, which includes the failure to adequately supervise a child, and environmental neglect, which involves exposing a child to dangerous situations in their home or community. Neglect is defined as “chronic” when there is a persistent pattern over time resulting in an accumulation of harm that can have long term effect on the child's overall physical, mental, or emotional development.

Several issues make neglect cases more difficult to assess than other kinds of cases: 1) the legal standard that a parent need only be “minimally adequate” to care for a child; 2) the need to speculate about impending safety threats versus immediate safety threats to a child; 3) the need to monitor and observe over time to assess whether something is a pattern, or a singular event; and 4) the fact that access to resources in a community vary greatly across the state.

The Oregon Safety Model (OSM), adopted in 2007, requires a worker to conduct comprehensive assessments, instead of incident-based assessments. Earlier this year, the department consulted with the National Resource Center (NRC) on Child Protective Services about its efforts to fully implement the OSM. While the NRC concluded that Oregon is on track in terms of implementation and execution of its practice model, it acknowledged that in the progression of implementation, there

would continue to be areas of struggle with respect to caseworker application of the comprehensive assessment in specific kinds of cases.

Neglect cases represent the largest number of cases in Oregon. In a recent event, an Oregon Summit on “Moving Beyond Foster Care” sponsored by Casey Family Programs, the National Governor’s Association and the National Conference of State Legislatures, national and local experts presented information regarding the growing body of knowledge regarding neglect and its impact of child welfare practice. Those experts acknowledged the difficulty of appropriately assessing and effectively intervening in cases where neglect is present.

(<http://oregon.gov/DHS/children/beyondfc/features/news-summit-convenes.shtml>).

### **Recommendations:**

- The Department should consult with experts – both within Oregon and nationally – to create an inventory of national best practices for assessing neglect cases. The Department should then use that information to evaluate whether any changes to Oregon’s assessment process (policy and practice) need to be made to improve its response to neglect cases before those cases become chronic.
- The Department should develop a specific training for caseworkers and supervisors focusing on best practices when assessing neglect cases.

### **Issue #2: Child welfare workers need additional tools to assess and appropriately address safety concerns in cases involving the children of parents with developmental disabilities.**

Child Welfare continues to improve its understanding and service provision in cases that involve domestic violence and drug and alcohol issues (the vast majority of child abuse and neglect cases). However, different tools and skills are required to assess safety concerns and parental capacity when parents have developmental and cognitive challenges. In this CIRT, the team consulted with a representative from the developmental disabilities program area who opined that these tools do not readily exist, particularly tools that will allow for adequate evaluation of a parent’s cognitive challenges when that individual also presents with a co-occurring mental health and/or substance abuse disorder.

### **Recommendations:**

- Child Welfare and the Seniors and People with Disabilities Division, Developmental Disability Services program area, will collaborate to identify

expertise and resources from around the country and/or state that will help child welfare develop the appropriate tools to assess the parenting skills and capacity of individuals of parents with cognitive and/or developmental disabilities.

Areas identified for exploration are: a) tools to assess the parenting skills of individuals with developmental disabilities; b) training, interventions and supports for developmentally disabled adults who are parenting; and c) experts who can provide comprehensive evaluations to assist the department in protecting children while providing services to these parents.

- SPD will conduct a search of resources and experts available within the Developmental Disabilities system which will inform Child Welfare's efforts to better educate field staff around resources that are available.
- Child Welfare and SPD will also engage in conversations with the Oregon Council on Developmental Disabilities to seek their perspective and counsel on the policy issues raised by the overarching policy issue outlined below.

### **Overarching Policy Issues for Further Discussion**

Child Welfare services are intended to be temporary, short-term interventions to support a family's ability to safely parent their child/children. Recognizing that out-of-home placement is traumatic for families and often leads to poor outcomes for children, Oregon has been working to implement strategies that will safely and equitably reduce the use of foster care. However, in some cases involving parents who are developmentally disabled, those parents may not cognitively be able to develop the skills necessary to independently and safely parent their children without ongoing, long-term supportive services.

The overarching policy issue is how child welfare can adequately and appropriately interface with parents who have developmental/cognitive delays. This is addressed in three parts: 1) How to assess a developmentally delayed parent's ability to protect and safely parent their child; 2) How those parents can respond to community safety standards and support to prevent and maintain the safety of their children; and 3) If a case is open, how can DHS best provide services to meet the parent and child's needs. These dynamics lead to the following policy question: What is the most appropriate intervention – other than child welfare – for those parents and their children?

In a related policy issue, safely maintaining children at home with their parents – rather than bringing those children into foster care to ensure their safety – will likely require Oregon to think differently about the array of services available to support of parents with developmental disabilities, especially in rural parts of the state. In this case, the CIRT team recognizes the challenges involving access to services for these parents because child welfare workers tried to connect both parents to appropriate services, but none were available in this small, rural community.

### **Audit Points**

- 1) The department will consult with research and practice experts on specific and targeted training around identifying and assessing cases of neglect, including chronic neglect. This should occur no later than April 2011.
- 2) The department will collaborate with the identified expert to develop this training. This should occur no later than June 2011.
- 3) The department will mandate that this training be provided to all workers. This should occur no later than December 2011.
- 4) The department will create a plan for dissemination to the field available resources through the Developmental Disabilities services array. This should occur no later than June 2011.

### **Purpose of Critical Incident Response Team Reports**

Critical incident reports are to be used as tools for department actions when there are incidents of serious injury or death involving a child who has had contact with DHS. The reviews are launched by the Department Director to quickly analyze department actions in relation to each child. Results of the reviews are posted on the DHS Web Site. Actions are implemented based on the recommendations of the CIRT members.

The primary purpose is to review department practices and recommend improvements. Therefore, information contained in these incident reports includes information specific only to the Department's interaction with the child and family that are the subject of the CIRT Review.