CRITICAL INCIDENT RESPONSE TEAM INITIAL 30 DAY REPORT
S.H.

October 26, 2010

Executive Summary
On September 11, 2010, 16-month-old S.H. died from what authorities have determined as an overdose of Benadryl. The circumstances surrounding the death are currently under law enforcement investigation. The Oregon Department of Human Services (DHS) had received referrals on the family prior to the report about the fatal incident.

Any time a child in Oregon dies or is seriously injured as a result of abuse or neglect, the Department is committed to evaluating its processes and learning how the child welfare system may be improved in order to keep Oregon’s children safer as a result. The Critical Incident Response Team’s (CIRT) efforts to identify issues are an important component of agency accountability and improvement when tragedies like this occur. In addition to the CIRT, but in a separate process, the department will address any necessary personnel actions.

A preliminary review of the files has identified two potential systemic issues regarding the Department’s work in this case:

- First, the agency’s response to safety issues that appear to be, at least in part, associated with chronic neglect; and
- Second, the agency’s response when protecting children of parents with developmental disabilities.

The CIRT team is continuing its investigation into these issues and is seeking additional information. As the review of the case continues, the CIRT members will analyze whether the issues identified in this case are in fact systemic issues or unique to this case, whether there are any additional systemic issues to address, and draft recommendations to address them. We expect a final report on this case to be completed in December.

Summary of Reported Incident
On September 11, 2010, an on-call worker was notified by police that 16-month-old S.H. had been transported to the hospital after overdosing on Benadryl. Efforts to resuscitate the child were unsuccessful.
On September 14, 2010, DHS Director Dr. Bruce Goldberg determined that a CIRT be convened. This is the Initial 30 day report.

**Background**
As noted, the criminal investigation in this case is ongoing. Rather than delay the release of this initial report pending conclusion of that investigation, the details regarding the Department’s history with this family will be included in a subsequent report.

**Issues Identified**
As required by CIRT protocol, the first meeting convened within 24-hours of the CIRT being assigned. At that meeting, the team reviewed preliminary information and identified issues of interest in the case. An extensive file review was conducted and the results were presented at its second meeting. At that time, the team identified the following issues:

**Issue #1:** The agency’s response to safety issues that appear to be, at least in part, associated with chronic neglect.

**Issue #2:** The agency’s response when protecting children of parents with developmental disabilities.

**Next Steps:**
- Oregon’s revenue challenges are impacting the ability of an increasing number of families to find and secure jobs, food and shelter. In some instances, economic hardship may create unsafe environments for children and add to conditions that result in repeated referrals regarding a family and its circumstances. The issue of chronic neglect is sometimes compounded by varying community standards across Oregon. The CIRT will review the Department’s current practice when assessing these cases for child safety threats in light of national best practices and determine whether to recommend any changes or enhancements to Oregon’s assessment practice in cases where economic hardship appears to threaten child safety.

- The CIRT will include an individual with expertise in services to parents with developmental disabilities from the DHS Seniors and People with Disabilities division. The team will collaborate with that individual and any other experts, as needed, to develop recommendations regarding the work of child welfare to protect the children of parents with developmental disabilities.
• In recent years, the department reviewed a CIRT involving parents with developmental disabilities. The team should review the department’s actions in response to the CIRT recommendations from that review and include a report of findings of similarities and differences in the two incidents and lessons learned in the final CIRT report for S.H.

**Audit Points**
None at this time

**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.