

D.B. CIRT Public Report

Date	March 26th 2019
Date of Initial Report	January 24 th , 2019
Purpose Statement	Critical incident reports are used as tools for Department actions when the Department becomes aware of a critical incident resulting in a child fatality that was likely the result of abuse and the child, child's sibling or another child living in the household with the child has had contact with the Department (DHS). The reviews are called by the Department Director to quickly analyze DHS actions in relation to the critical incident and to ensure the safety and well-being of all children within the custody of DHS or during a child protective services assessment. The CIRT recommends which actions should be implemented and which individuals should be responsible for evaluating the implementation. Reports must not contain any confidential information or records that may not be disclosed to members of the public. Versions of all reports are posted on DHS' website.
Executive Summary	The Department received a total of four reports regarding D.B.'s family dating back to 2012. Of the four reports, one was closed at screening. After D.B. was born, DB was critically injured by the biological parents and placed into foster care. DB was subsequently adopted in 2017 and died shortly after the adoption finalized. Because DB was not in the care of the Department at the time of death, the fatality was not initially determined to fit the requirement to be considered a critical incident. However, after further examination of the file, it was determined the death met criteria for a CIRT, which was then declared in December of 2018.
Summary of Critical Incident	In March of 2015, D.B was hospitalized due to a subdural hematoma and two different stages of brain bleeding. Upon further examination, medical providers also found a healing rib fracture. The parents were unable to explain how D.B. suffered such extensive trauma. They claimed D.B. had ongoing seizures suggesting that might be responsible for the injuries. They admitted never obtaining treatment

	<p>for D.B.'s seizures. Regardless, medical professionals noted seizures would not account for D.B.'s injuries. D.B. was placed into foster care and eventually adopted. DB died in 2017 from persistent complications related to the injuries the child sustained.</p>
<p>Evaluation of Department Actions</p>	<p>The Department did not identify any systemic issues related to D.B.s death. However, two practice concerns were noted:</p> <ul style="list-style-type: none"> • The Department's history with the family reflected previous interventions due to child safety concerns. A variety of services were provided to address these issues. However, outside of mere attendance, it is unclear how it was determined the parents could provide safe parenting as distinct goals were not defined. • The Department's comprehensive assessment of the family was limited by their resistance to participate during the Child Protective Service (CPS) assessments. Oregon Administrative Rule requires collateral contacts be made to provide supplemental information in order to determine if a child(ren) are safe. This is especially important when families are unwilling to provide information. Department records show collateral contacts were not always made.
<p>Recommendations for improvements and associated tasks</p>	<ul style="list-style-type: none"> • No systemic child welfare issues were identified therefore no associated tasks were recommended by the CIRT. • The noted practice concerns will be addressed through local branch training.
<p>Methods of evaluating expected outcomes</p>	<p>N/A</p>