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.

<table>
<tr><td colspan="3">CIRT ID: 8WEL4X8344</td></tr>
<tr><td>Date of critical incident:

January 7, 2022</td><td colspan="2">Date Department became aware of the fatality:

January 7, 2022</td></tr>
<tr><td>Date Department caused an investigation to be made:

January 7, 2022</td><td colspan="2">Date of child protective services (CPS) assessment disposition:

March 13, 2022</td></tr>
<tr><td>Date CIRT assigned:

January 12, 2022</td><td colspan="2">Date Final Report submitted:

April 20, 2022</td></tr>
<tr><td>Date of CIRT meetings:

January 31, 2022
March 22, 2022</td><td>Number of participants:
15
18</td><td>Members of the public?

Yes
Yes</td></tr>
</table>

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

Date of report: January 7, 2022 **Assignment decision:** Within 10 business days	**Allegation(s):** Neglect	**Disposition(s):** Founded

On January 7, 2022, ODHS received a report stating the mother had woken up and found her almost two-week-old child was not breathing. The mother called 911 and was coached on how to perform CPR until EMS could arrive. EMS was not able to revive the child, and they were pronounced deceased at 6:23 a.m. The mother and child were said to be houseless and had been staying at a motel at the time of the child's death. The reporter stated three unknown adults had been seen coming and going from the hotel room on the evening prior to, and morning of, the fatality but were not present when EMS arrived. A broken methamphetamine pipe was found on a dresser in the motel room, but the mother denied using any substances.

The CPS caseworker responded to the mother's motel room on the morning of January 7, 2022 and met law enforcement while the mother was still present. Alcohol and drug paraphernalia were observed in the room, and the detectives on the scene reported the mother appeared to be under the influence of substances. After leaving the motel, the mother went to the police station for a more comprehensive interview. The CPS caseworker was able to observe the interview from another room but had difficulty hearing some of the mother's responses.

The CPS caseworker later reviewed police reports regarding the child's death. In interviews conducted on the scene, and later at the police station, the mother explained the events that occurred from the time she checked into the motel to the time she found the child non-responsive. She stated she checked into the motel on January 6, 2022, at approximately 1:00 p.m. accompanied by a friend. She said the friend left after about an hour. The mother said she then fed the child, using the last of her formula. She then called another friend and asked them to bring more formula to the motel. The mother reported her friend arrived at the motel with the formula sometime between 9:00-11:00 p.m. The mother then reported that she prepared a bottle and fed the child. She indicated that she and her friend took turns caring for the child and another friend came over for a short time. She said she left the room a few times to smoke or to get ice, leaving the child in her friend's care. The mother reported her friend left between 1:00-2:00 a.m. She described how she put the child to sleep, swaddled, on their back, laying on top of a blanket that was spread over pillows. She said the last time she put the child to sleep her

arms were around the infant. She recalled she was likely still touching the child when she unintentionally fell asleep on her knees next to the bed. When she woke, she said she found the child face down and not breathing, so she called 911. When the mother was asked how she believed the child ended up face down, she suggested the child may have rolled over on their own. When the detective informed her a two-week-old infant could not roll over on their own, the mother then suggested the blanket or pillow could have shifted. The CPS caseworker later contacted the social worker at the hospital where the child was born and confirmed safe sleep practices had been reviewed with the mother prior to the child being released.

The mother was asked about a bottle of hard seltzer found in her room and she reported drinking some of it around 4:00 p.m. and then finished the rest of it at approximately 10:00 p.m. When questioned about the drug paraphernalia in the room, she explained getting one piece from a neighboring room and said she could not remember where the other piece came from. She denied using heroin or methamphetamine since learning she was pregnant with the child but admitted to recently using a relative's vape pen and later learning the pen had methamphetamine in it. She said if she were to be tested for substances, only alcohol and marijuana would be detected. The detective noted the mother appeared to be exhibiting signs of withdrawal during her interviews and was reported to be sleeping between interviews.

A search warrant was obtained for the mother's room. Police found a bottle of whiskey and a large quantity of nitrous oxide cartridges, which are commonly referred to as "whippets" by those who use them as inhalants. Also found in the room were pieces of tin foil with burned residue on them and a sealed dose of Narcan. A search warrant was later executed on the mother's phone. Messages and calls on the phone indicated the mother made numerous attempts to contact two friends in the minutes preceding her call to 911. There were also messages found from the week preceding the child's death where the mother was trying to acquire "blues," a common street term for often-counterfeit M30 oxycodone pills that can sometimes contain fentanyl. Also found in the mother's phone was a bookmarked web page with information on how to clean an unborn infant's body of drugs.

A detective interviewed the mother's friend who was at the mother's motel room prior to the child's death. The friend reported the mother called on January 7, 2022 and asked her friend to bring formula to the motel room. The friend arrived at the motel with another person who left after about an hour. The friend reported concerns the mother was using substances that evening and observed her to be nodding off several times while the friend was there. The friend was concerned the mother was not paying enough attention to the child and said the only care she saw her provide to the infant was to prop the child up on the bed with a bottle that was propped up on a blanket. The friend offered to care for the child to give the mother a chance to sleep, but she did not go to sleep and seemed preoccupied with her phone. At one point, they both went outside the room to smoke, and

the room door shut with the child locked alone inside. The friend told the mother to run to the office to request to be let back into the room and said the mother slowly walked to the office instead. The friend reported leaving the motel around 2:30 a.m. and said the mother called later in the morning to report the child was not breathing and asked for advice on what to do. The friend advised her to call 911.

The allegation of neglect by the mother to the child was determined to be founded as there was reason to believe the mother was under the influence of substances and was not attentive to her child's care needs during the events leading up to the child's death.

Description of relevant prior Department reports:

Date of report: December 26, 2021 **Assignment decision:** Closed at Screening	**Allegation(s):** Threat of Harm	**Disposition(s):** Not Applicable

On December 26, 2021, ODHS received a report the mother had given birth to the child. The report stated the mother tested positive for THC at the time of the delivery and she had disclosed using suboxone a few days prior to the child's birth. It was not known whether the mother was prescribed the suboxone, and the reporter was also not aware of the extent of the mother's marijuana use. It was reported the child had a difficult delivery as vacuum assist was needed and the umbilical cord was wrapped around the child's neck. The child was said to be in the Neonatal Intensive Care Unit (NICU) due to respiration problems and will be released once breathing has stabilized.

The mother was said to have received limited prenatal care, cancelling all but three appointments. The mother was said to be staying with a friend after experiencing housing instability prior to the child's birth. It was unknown what kind of support system she had.

The report was closed at screening as it was determined to not be a report of abuse.

Date of report: January 4, 2022 **Assignment decision:** Within 24 hours	**Allegation(s):** Neglect	**Disposition(s):** Founded

On January 4, 2022, ODHS received a report the child's umbilical cord drug screen had been positive for THC and opiates. It was also reported the mother had stated she used unprescribed suboxone a few days prior to the child's birth. The report indicated that mother and child were either staying at the home of a relative or a friend. The child's biological father was reported to be incarcerated and expected to remain incarcerated for three years. The report was assigned for an allegation of neglect with a 24-hour response timeline.

The assigned CPS caseworker contacted law enforcement on January 4, 2022 and learned of three possible addresses for the mother in two counties. That afternoon, the caseworker attempted to contact the mother and child at two of the addresses but was not successful. On January 5, 2022, a request was made for a CPS courtesy caseworker to attempt contact with the mother and child at the address of the mother's friend in another county. The courtesy caseworker made face-to-face contact with the mother's friend the following day. The friend said the mother moved into the friend's home just prior to the child's birth and left the home on January 1, 2022. The friend was concerned the mother was depressed and suspected she was using substances.

On January 7, 2022, while this assessment was open, ODHS received a report the child had died. The allegation in this report was assessed together with the allegation regarding the child's death and the results were documented in one report.

Law enforcement later interviewed the friend with whom the mother and child had been residing with at the time of the child's birth. The friend stated they had known the mother for more than half of the mother's life but had not had contact with the mother for several months before the mother called in early December 2021.The friend met with the mother and agreed to allow the mother to stay in their home. The mother moved into the friend's home shortly before giving birth to the child. The friend described the mother as fearful about having a baby with limited support. The mother shared she had struggled with depression and substance use in the past, but the friend assumed the mother stopped using substances when she learned she was pregnant. When the mother and child were released from the hospital, they returned to the friend's home. The friend reported the mother did not have the items necessary to care for an infant, so the friend bought the mother a pack-n-play, diapers, and other necessary items. The friend did not report any concerns for the mother's care of the child; however, the mother and child only stayed for a few days, leaving on January 1, 2022. Most of the items purchased for the child's care, including the pack-n-play with bassinet, clothing, and bath items, were left behind. The friend reported that after the Child Welfare courtesy caseworker came to her home on January 6, 2022, she messaged the mother, but never heard back.

The CPS caseworker interviewed a hospital social worker who reported no concerns for the mother's behavior at the time of the child's birth but noted the mother's friend seemed to be providing for much of the child's care rather than the mother.

Law enforcement conducted interviews with two other friends of the mother who both reported having concerns for the child while in the mother's care. They described incidents where the mother was inattentive to the child's needs. One friend reported bringing formula to the motel where the mother and child were staying on the evening of January 6, 2022 after learning the child had not been fed since that morning. The friend said the mother was hesitant to wake the child to feed them, as the child had just cried themself to sleep. The friend said the mother acted like it was a burden to have to feed the child. The other friend reported an incident where it appeared the child was choking and the mother was asked to help the child, but the mother failed to respond so someone else intervened. Both friends reported having another friend check on the child while the mother was staying at a motel as they were concerned about the child in the mother's care.

The allegation of neglect by the mother to the child was determined to be founded based on information gathered about the mother's care of the child prior to the critical incident.

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 noted there was insufficient information available regarding the frequency of mother's substance use and any potential impacts to the mother's parenting of an infant at the time of the December 26, 2021 closed at screening report. This resulted in the information not meeting criteria for a CPS Assessment assignment. Limited information can be a barrier to understanding potential risks and supports needed for a parent and infant at the time a child is born substance exposed. While more detailed information came to light nine days later, which subsequently resulted in a CPS Assessment, the mother and infant had already been discharged from the hospital and diligent efforts by multiple caseworkers were not successful in locating them prior to this tragic outcome.

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:

Exploration by the CIRT on this case and previous similar cases continue to highlight a critical need for Oregon to continue to prioritize and build infrastructure for universal, upstream pathways for holistic services and supports for pregnant persons who are using substances. Pregnant persons struggling with substance use can be especially vulnerable as pregnancy may amplify the stigma of a substance use disorder, which may

lead to limited or no prenatal care and be a barrier to seeking Substance Use Disorder (SUD) treatment and supports during pregnancy.

The CIRT supports measures to continue to build upon the federally legislated Comprehensive Addiction and Recovery Act (CARA) implementation in Oregon, which highlights the need for upstream resources, services and connections for the unique needs of pregnant persons and their infants born substance exposed. This federal Act supports an integrated care model that includes partnerships and agreements with ODHS, health professionals, substance use disorder treatment programs, early childhood education programs, maternal and child health, early intervention professionals, juvenile and family court judges, social services agencies, and peer-to-peer recovery programs to do this important prevention work together. The Child Fatality Prevention & Review Program is enhancing Child Welfare's workforce knowledge and skill around the development of a Plan of Care, which is an integral part of CARA and required when a Plan of Care has not already been completed by medical professionals. Plans of care are most successful when family serving systems come together to ensure a family has their identified needs met, which may include SUD treatment, mental health services, peer support, and concrete needs. The CIRT continues to strongly support the work that is happening in the Nurture Oregon Pilot, which offers a continuum of integrated care for pregnant persons, infants exposed to substances and their families.