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.

CIRT ID: NXFX87DBL0		
Date of critical incident: February 18, 2025	**Date Department became aware of the fatality:** February 18, 2025	
Date Department caused an investigation to be made: February 18, 2025	**Date of child protective services (CPS) assessment disposition:** May 29, 2025	
Date CIRT assigned: February 24, 2025	**Date Final Report submitted:** June 4, 2025	
Date of CIRT meetings: March 24, 2025 April 28, 2025	**Number of participants:** 11 19	**Members of the public?** No Yes

Level 3 - Restricted

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

Date of report: February 14, 2025 **Assignment decision:** Within 72 Hours	**Allegation(s):** Threat of Harm by the parents	**Disposition(s):** Unfounded
Date of report: February 18, 2025 **Assignment decision:** Within 10 Business Days	**Allegation(s):** Neglect by the parents	**Disposition(s):** Founded

On February 14, 2025, ODHS received a report the child, who was five months old at the time, was last weighed at their pediatrician's office when they were three weeks old, and they were in the less than first percentile for their weight. The reporter stated there were concerns at the time for failure to thrive. Since then, the child's parents had missed five confirmed medical appointments and had not been communicative with staff at the office. The reporter stated when staff at the pediatrician's office call the parents, the parents hang up on them. The parents were referred to a lactation specialist for the child but had never followed through. Allegations of threat of harm to the child by the parents were assigned for CPS assessment with a 72-hour response time. The allegations in this report were assessed along with the allegations regarding the child's death on February 18, 2025, and the results were documented in a single report.

On the day the report was made, the CPS caseworker staffed the report with their supervisor and another CPS supervisor before responding with a co-worker to the family's home. Three different residences were found at the address. The caseworkers spoke with a person who lived at one of the residences and they directed them to the family's home. A person answered the door and identified themself as a roommate and reported the family was currently out of town. The roommate did not have any concern

for the health and safety of the child. The CPS caseworker left a card with the roommate and asked them to have the parents call them. The CPS caseworker then spoke to the parents by phone. They stated they were visiting the child's relatives in another city and would arrive back home on the evening of February 17. The parents reported the child was doing well and weighed 13 pounds when weighed at the WIC (Women, Infants, and Children) office in mid-January. The father said the child was scheduled for an appointment with their pediatrician on February 18 and explained they missed the child's most recent appointment due to the father needing to attend job interviews. He explained they had missed another appointment for the child due to being out of town for the holidays. The mother stated the child was taking 10 ounces of milk every two hours and was eating baby cereal once a day. The parents reported receiving a 30-day eviction notice and said they were working with two local agencies to acquire housing.

On February 18, 2025, ODHS received a report the child had passed away earlier that day while bed sharing with their parents. Both parents stated they used marijuana before going to bed with the child the previous evening. The mother also reported taking two double shots of alcohol before taking the child to bed. The father had gone to bed prior to the mother and child joining him. The mother was lying in the middle of the bed with the father on one side of her and the child on the other side. The reporter stated the mother woke to find the child on their stomach, under her arm, and unresponsive. She contacted 911 at 5:52 a.m. First responders declared the child deceased at 6:41 a.m. The condition of the family's home was reported to be concerning as it was in disarray, full of trash, and first responders had to walk on the mattress to access the parents' room. The parents stated the home was not typically in this condition and explained they were packing as they were being evicted. The reporter did not notice any boxes or other signs the parents were packing. Allegations of neglect to the child by the mother and father were assigned for CPS assessment with a 10-business day response time.

On the day of the incident, the CPS caseworker, their supervisor, and a Coaching and Training Specialist (CTS) worker spoke with a detective assigned to the case. The detective explained the fatality as an accident and stated it appeared the mother had rolled over onto the child while she

was asleep. The child was described as small, but not malnourished, with no visible injuries. No formula was observed in the home, but a baby bottle was present on a table. The home was reported to be cluttered and in disarray. The detective said they would provide photos of the scene to ODHS. The detective stated in the week prior to the incident a maternal relative had picked the child up from the parents on February 11 to take them to another city, and the parents met them there on February 14. The parents stated they returned home on February 17 about 6:30 p.m. The CPS caseworker then requested records from the child's pediatrician's office, the local hospital, the state police, and from the WIC office. A CTS worker requested rush toxicology, which was approved.

On February 20, 2025, the CPS caseworker spoke to a deputy who responded to the home on the morning of the incident. The deputy stated the parents' roommate, the roommate's partner, and a third person were also in the home at the time of the child's death. The third person was reported to be a sex offender who was not permitted to have contact with children. The deputy stated the mother, father and child were sharing a mattress in the home at the time of the incident. The mother reported the child had been recovering from a cold at the time of their passing. The parents did not answer when asked the name of the child's pediatrician. The mother said she had stopped nursing the child a few months prior and had switched to formula and formula was observed to be on the dash of the family's vehicle. The condition of the home was said to be concerning, but the deputy said nothing was observed that would indicate the child's death was the result of abuse. The CPS caseworker then spoke by phone to the father who reported the child had passed away in their sleep. He said the mother was currently sleeping and would not be up until later in the afternoon.

Later in the day, the CPS caseworker and a CTS worker interviewed the mother and father at the ODHS office. Both parents acknowledged being made aware of safe sleep practices in the hospital at the time of the child's birth, and the mother said she would become upset with the father when he would try to sleep with the child on the couch. The mother said the child would typically sleep in a pack 'n play in the living room while she slept in the bedroom. She reported she was a light sleeper and could hear the child in the living room when they would wake. On the evening of the child's

death, the mother said the family had returned from visiting relatives in another city around 7:45 p.m. and she had smoked two bowls of marijuana and took two shots of alcohol offered to her by a roommate shortly after arriving home. She stated the marijuana use was typical for her, but the drinking was not. She denied any other substance use that evening. The father reported being diagnosed with schizophrenia, bipolar disorder, and major depressive disorder. He denied daily alcohol use but said he would occasionally drink on the weekend. The father said he was in bed by 1 a.m. and the mother said she brought the child to bed with her at 3 a.m. She stated she brought the child to bed with her so she could prop them up, as they were sick, explaining the child had developed a cough in the week prior to their passing. The mother denied being under the influence of substances at the time she went to bed with the child and the father stated he did not observe her to be under the influence at the time as well.

The CPS caseworker then spoke to the parents' ODHS Self-Sufficiency family coach. They reported attempting a home visit with the family in the past and said they had spoken with the parents daily by phone in the month prior to the child's death. The mother had reported concerns there was black mold in the family's home, the windows were broken, there was no power, and it was cold. The family coach noted the mother's voice would change during phone conversations and said the mother had stated she had experienced depression in the past and was waiting on a decision as to whether she qualified for Social Security benefits due to the diagnosis.

On February 21, 2025, the CPS caseworker left a message for a maternal relative requesting a call back. The caseworker then spoke with a paternal relative who reported having contact with the child on four or five occasions and stated the parents were very attentive to their needs. The paternal relative said the parents would place the child to sleep in a pack 'n play and that just prior to their death the child was attempting to roll over and crawl. The paternal relative had not witnessed the parents co-sleep with the child. The paternal relative said the family was at their home on the weekend prior to the child's death. The child had been brought to their home by a maternal relative and the parents arrived a few days later. They stated the child had a mild cold at the time. The paternal relative said the parents had reported missing a few medical appointments for the child due to the father needing to attend job interviews. In a later conversation with the CPS

caseworker, the paternal relative said they had never been to the parent's home. They said the child would nap frequently throughout the day, would be put to sleep at 8 p.m., and typically wake for an hour or so during the night. The relative reported both parents cared for the child and would take turns getting up with him so the other could sleep.

The CPS caseworker then spoke with a collateral contact who had responded to the home on the morning of the child's passing who said the mother reported the child was always placed to sleep on their back and she would co-sleep with them two or three times a week. The child's bassinet was said to be so full of items it did not appear as if it was being used anymore. The collateral contact said both parents reported regular marijuana use. On the day of the child's passing, the father said he went to bed around 1 a.m. and always smoked marijuana prior to going to bed. The mother said she brought the child to bed at 3 a.m. and woke to find them halfway on their stomach and under her arm. The collateral contact said a lactation referral was made for the family at the time of the child's birth and another referral was made on January 27 but canceled due to a lack of follow up by the parents.

On March 3, 2025, the CPS caseworker spoke with a staff member at the local WIC office who reported the family had last been seen in person for a weight check in October 2024 when the child weighed 6 pounds and 7 ounces. The parents followed up with a dietician in December to discuss switching to formula. The family was due for another appointment with WIC on March 19. On March 4, the CPS caseworker received information the child weighed 14 pounds at the time of their death.

On March 6, 2025, the CPS caseworker and a CTS worker spoke with the parents by phone. The mother and father stated they were unwilling to complete releases of information for their medical and mental health records.

On March 18, 2025, the CPS caseworker spoke with the parents' roommate. The roommate stated the mother and father were good parents who were attentive to the child's needs. They said when they first moved in with the family in October 2024, the child was taking 2 to 4 ounces of milk per feeding and prior to their death they were taking about 5 ounces per feeding. The roommate reported the parents had taken the child to the

emergency room three months earlier when they had a cold and stated the child also had a cold at the time of their passing. On the evening prior to the child's death, the roommate said the family returned home from visiting relatives in another city between 6 and 8 p.m. and that they, the mother, and two others had a few beers. When asked about the mother's substance use that evening, the roommate reported her drinking a single can of Mike's Hard Lemonade and said the mother appeared to be sober. The roommate denied any other substance use by the mother that evening. They believed the mother took the child to bed about 9-10 p.m. and said the parents usually slept with the child as they would cry when placed in their crib.

On March 25 and 26, the CPS caseworker spoke with a staff member from the child's pediatrician's office who confirmed the child had last been seen there on September 20, 2024, when they were just a few weeks old and weighed 5 pounds 6 ounces. At the time they were considering a diagnosis of failure to thrive for the child. Since then, the family had either canceled, asked to reschedule, or had not shown up for many appointments, most recently in February 2025. On February 14, 2025, the mother reportedly hung up the phone when contacted by the pediatrician's office. The practice received records the child was seen at the emergency room on January 1, 2025 due to a cough and runny nose and was diagnosed with hand, foot and mouth disease as well as pharyngitis. In a later conversation with the pediatrician's office the CPS caseworker was told a normal weight for an infant of the child's age would be 13 pounds.

On April 14, the CPS caseworker spoke with a collateral contact who reported substance use concerns for the parents, stating they were heavy marijuana users and struggled to make good decisions. The contact also said the mother was an alcoholic but had refrained from alcohol use during the second half of her pregnancy. They reported the father had cognitive delays and both parents experienced considerable instability as children. The collateral contact stated both parents had significant mental health challenges as well and the mother did not always take her medications. They said the family's home was heavily cluttered, unsanitary, and they had observed marijuana left out on the kitchen table.

The allegations of threat of harm to the child by the parents were determined to be unfounded as it was decided allegations of neglect were more appropriate.

The allegations of neglect to the child by the parents were determined to be founded. On the evening of the child's death, the mother used alcohol and marijuana prior to sharing a sleeping surface with her child, who was ill, and both parents acknowledged being aware of safe sleep practices but did not follow them. Additionally, the parents failed to maintain a safe and sanitary living environment for the child and missed numerous medical appointments for the child despite significant concerns for the child's health.

Description of relevant prior Department reports:

Date of report: January 24, 2025 **Assignment decision:** Closed at Screening	**Allegation(s):** No Allegation	**Disposition(s):** Not Applicable

On January 24, 2025, ODHS received a report the child, who was 4 months old at the time, had not been seen for a well child check since they were a few weeks old. At the time of that appointment the child weighed 5 pounds and 6 ounces, putting them at less than the first percentile for weight. Since that time, the child's parents had failed to bring the infant in for four follow-up appointments that were either canceled or rescheduled and they had missed four other appointments. The pediatrician's office had spoken with the mother on the day prior to each appointment and it was unknown why the family kept missing them. The report was closed at screening as it was determined not to be a report of abuse.

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 identified that the reports made on January 24, 2025, and February 14, 2025, were nearly identical, despite the January report being

closed at screening and the February report being assigned for a Child Protective Services (CPS) assessment and noted disagreement between participants of the CIRT regarding the first report being a report of abuse. The February report included two additional pieces of information: that the child's pediatrician was considering a diagnosis of failure to thrive and that the parents had been referred to a lactation specialist but did not follow through. Although the definition of child medical neglect specifies that failure to provide a child with routine well-child appointments does not, in of itself, constitute neglect, it also indicates that frequently missed appointments that result in, or are likely to result in, the worsening of a child's illness or injury are considered neglect. Both reports noted that the child's weight was 5 pounds 6 ounces and in less than the first percentile during the one documented medical visit when the child was two weeks old, a condition that warranted further monitoring and follow-up. In this context, subsequent well-child appointments should not be regarded as routine. Had additional information been gathered from the reporter about the potential impact of missed appointments on the child's health and well-being, it might have prompted the assignment of the January 2025 report for CPS intervention, thus providing an opportunity to engage with and offer support to the family sooner.

The CIRT also observed a recurring concern of parental marijuana use in connection with sleep-related infant fatalities, both in this case and in previous cases. In response, the agency is actively developing several strategies to educate staff, families, as well as medical and community partners, regarding the potential impact of parental marijuana use on infant safety. These efforts aim to enhance awareness and ensure better prevention measures are in place.

Despite the limited time between the assignment of the CPS assessment and the report of the child's passing, the CIRT discussed the possibility of requesting a courtesy CPS caseworker to contact the family in the county they were visiting. At the time of assignment, diligent efforts were made to reach the family, and it was quickly determined that they were visiting relatives in another county. Phone contact was made with the parents, and the information provided appeared reasonable, with the understanding that ODHS would conduct a face-to-face visit once the family returned to their home county.

Lastly, the CIRT recognized the vital role that Self-Sufficiency Family Coaches play in supporting families with young children. Family Coaches are assigned to families receiving Temporary Assistance for Needy Families (TANF) and work collaboratively with them to develop case plans that address barriers to meeting basic needs and achieving long-term self-sufficiency. Family Coaches can assist with practical challenges, such as helping families access medical care when transportation is limited. They can also provide education on safe sleep practices and parental substance use and help address concerning family conditions early—often preventing situations that might otherwise lead to child welfare involvement or reports of abuse.

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:

The team recommends that the ODHS Nursing Administrator provide education to Oregon Child Abuse Hotline staff on screening reports involving concerns about low infant weight. This should include guidance on gathering sufficient information to assess whether missed appointments could exacerbate the condition. Additionally, the guidance should offer further clarification regarding when the failure to attend well-child appointments meet the definition of medical neglect. This recommendation should commence no later than August 2025.

The CIRT recommends that the ODHS-Child Welfare and ODHS Self-Sufficiency Program explore referring closed at screening reports regarding infants to the family coaches of TANF recipients. This would enable family coaches to provide referrals and early supports for parents when the information reported does not constitute child abuse or neglect. This preventative approach aligns with the objectives of the Child Abuse Prevention and Treatment Act (CAPTA). While limited in scope, this preventative effort has been in place in Oregon for years. Further exploration and evaluation shall occur to assess whether expansion of this practice is warranted. The evaluation of existing practice and exploration of further expansion should commence no later than October 2025.