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: TCKE0BJQPR		
Date of critical incident: February 2, 2025	**Date Department became aware of the fatality:** February 2, 2025	
Date Department caused an investigation to be made: February 2, 2025	**Date of child protective services (CPS) assessment disposition:** May 15, 2025	
Date CIRT assigned: February 7, 2025	**Date Final Report submitted:** May 16, 2025	
Date of CIRT meetings: March 3, 2025 April 18, 2025	**Number of participants:** 14 19	**Members of the public?** No No

Level 3 - Restricted

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

Date of report:	Allegation(s):	Disposition(s):
February 2, 2025		
Assignment decision:	Neglect by the mother	Unable to Determine
Within 72 hours		

On February 2, 2025, ODHS received a report the mother had contacted 911 that day to report her 5-month-old child was not breathing and she was concerned one of her dogs may have bitten them. The child's 17-year- old sibling was also home at the time and flagged down first responders outside. Law enforcement and medical personnel were unable to revive the child, and they were pronounced deceased at the scene. The child was not observed to have any visible injuries. The mother said she had been bed sharing with the child in her room at the time she found them not breathing. She reported she went to bed with the child about 10 a.m. and woke up about 5 p.m. to find them unresponsive. The child's sibling said they went into the bedroom around noon to check on the child and they were still breathing. The mother said the child had been sick for several days with a cold and diarrhea and she had given them some over-the-counter infant cough syrup and teething medication. The reporter stated the home was cluttered, there were two dogs in kennels by the front door and a puppy in a bedroom. The mother reported one of the dogs in the kennels was out at the time she found the child unresponsive. Drug paraphernalia was located in the home, but the mother denied any substance use. A methamphetamine pipe, a pipe made from a light bulb, and a snort straw were found in a kitchen drawer. A methamphetamine pipe and another pipe that could be used for methamphetamine or marijuana was found under the kitchen sink. An ODHS cooperative in-home case was open at the time of the child's death. An allegation of neglect to the child by the mother was assigned for CPS assessment with a 72-hour response time.

On February 3, 2025, the CPS caseworker left a voicemail for a law enforcement officer with the child abuse team requesting updates on the case. On February 4, 2025, the CPS caseworker spoke to a collateral source who reported no physical trauma to the child was observed at the time of their death. Later, the CPS caseworker asked support staff to

request the child's medical records and the police report regarding their death. The CPS caseworker visited with the mother at home and provided her with a list of resources and supports. The child's sibling was not at home at the time of the visit.

On February 6, 2025, the CPS caseworker e-mailed two detectives assigned to the case requesting an update. On February 10, 2025, a detective responded there was no new information to report. Later, the CPS caseworker spoke with the mother's ODHS Self-Sufficiency Program family coach, who reported not knowing of the cooperative child welfare case with the family, which opened on October 1, 2024, until recently. The CPS caseworker then met with the mother and child's sibling at home.

On February 17, 2025, the CPS caseworker received the police report regarding the child's death. The mother told police she had been up all night with the child the previous evening, the child was teething, and they fell back asleep together about 10 a.m. She said she woke up later to find the child unresponsive. The police report reflects the mother reported concerns that one of her dogs may have gotten to the child as it was jealous of them and was out of its kennel at the time she found the child not breathing. No injuries were observed to the child. The child's sibling reported waking that morning around 10 a.m. and taking the dogs for a walk. At noon they went into the mother's bedroom and found the child and mother asleep on the bed. The child's sibling checked on the child's breathing by putting a hand on their stomach, then went back to bed as they worked the night shift at a local restaurant. The child's sibling said they woke about 5 p.m. after hearing their mother screaming. The child's sibling stated their mother handed them the child who was cold to the touch. The child's sibling said the child slept with the mother in the bed and not in a crib or bassinet. They stated the child would typically sleep on their back and the mother would sleep with an arm on the child's chest. The child's sibling reported one of the family's dogs was in bed with the mother and child that day and since the child had a bloody nose there was concern the dog had done something to them. The child's sibling said the dog could be a little violent but loved the child. The child's sibling acknowledged the mother's past use of substances including fentanyl to police but reported their mother was currently sober other than her use of marijuana.

On March 3, 2025, a referral for substance use treatment made for the mother prior to the child's death was closed due to a lack of engagement. On March 4, 2025, In Home Safety and Reunification Services for the family opened prior to the child's death were also closed out due to a lack of engagement. On March 14, 2025, the CPS caseworker learned the safety service provider for the family's open cooperative case with ODHS had been arrested for allegedly stealing over $1000 worth of merchandise from retail stores. It was later learned the child's sibling was with the safety service provider at the time of their arrest and was handcuffed briefly. At the time of the arrest suspected methamphetamine was found in the safety service provider's vehicle. The child's sibling had to drive home approximately 90 miles after the safety service provider's arrest.

On March 21, 2025, the CPS caseworker and a new permanency caseworker met with the mother and child's sibling at home. There were people present packing the family's belongings as they were being evicted and did not know where they would go next. The mother was asked about the events leading to the child's death. She said she woke that day at 10-10:30 a.m. to give the child a bottle and at 11 a.m. laid down to take a nap with them. She said she woke at 4 p.m. to find the child deceased and she yelled for the child's sibling. The mother said it was not unusual for the child to take long naps and she speculated their cause of death was related to mold in the apartment. When asked about the paraphernalia found in the home, she reported a marijuana bong belonged to the child's sibling. When the CPS caseworker read the police report with a description of paraphernalia found in the kitchen both the mother and child's sibling denied the items belonged to them. The mother reported sleeping more and using marijuana more since the child's death but denied any other substance use. When asked about the arrest of the safety service provider, the child's sibling reported being invited by them to go shopping and stated they stayed in the car while the safety service provider stole items from two retail outlets. The child's sibling said they had no idea the safety service provider was stealing items but added police were considering them an accomplice and discussing charging them criminally. The mother and child's sibling said they were no longer having contact with the safety service provider. The mother was asked about the identity of a person heard, but not seen, in the home when the permanency caseworker

visited the family on March 10, 2025. She explained they were an ex-partner who had attended the child's funeral. When asked if the individual was the mother's most recent partner and suspected father to the child, the mother and child's sibling denied that saying they were in prison. Throughout the course of the assessment the CPS caseworker offered the family assistance with grief and loss counseling resources as well as funeral and burial costs.

On March 26, 2025, the CPS caseworker staffed the case with their supervisor as well as the permanency caseworker, the permanency supervisor and the local safety and permanency consultants. It was recommended the CPS caseworker make additional efforts to assess the safety of the child's sibling in their mother's care. An allegation of neglect to the child's sibling by the mother was added to the assessment as was an allegation of neglect to the child's sibling by the safety service provider.

On April 1, 2025, the CPS caseworker spoke with the father of the child's sibling by phone. He reported the child's sibling had visited his home a few weeks prior and had disclosed the mother had relapsed on substances and was making efforts to become sober again. The father of the child's sibling asked the sibling to stay with his family, but they had refused.

Between March 26, 2025 and April 18, 2025, the CPS caseworker made numerous efforts to contact the mother and the child's sibling. On April 18, 2025, the CPS caseworker interviewed the child's sibling and the mother separately at the ODHS office. The child's sibling reported living with their mother at the homes of several of the mother's friends since their eviction. They stated they believed their mother had relapsed on substances shortly after their contact with ODHS on March 21, 2025. The child's sibling denied witnessing their mother use substances but said they could tell she had relapsed by her behaviors. The child's sibling also disclosed they believed the safety service provider for the family was using substances prior to the child's death based on their behaviors. However, the sibling did not feel the mother and safety service provider were using substances together. When asked about the paraphernalia found in the home at the time of the child's death, the child's sibling stated people using substances would visit the home and the sibling speculated the paraphernalia belonged to either their mother, the safety service provider, or one of the persons who would visit.

The child's sibling reported having some concerns for their own safety in their mother's care since the mother's relapse. The CPS caseworker spoke with their supervisor and was instructed to make a safety plan for the child's sibling. When the CPS caseworker spoke with the mother about concerns for the safety of the child's sibling, she became upset with the child's sibling for their disclosures, said she was done with them, and walked away resulting in the child's sibling being without a caregiver. At the conclusion of the assessment an out of home safety plan was implemented for the child's sibling as they were found not to be safe in their mother's care and they refused to be placed in their father's care due to past trauma.

The allegation of neglect to the child by the mother was coded as unable to determine. Despite concerns regarding the mother's substance use and drug paraphernalia being found in the home on the day of the critical incident, there was insufficient evidence to suggest the mother's actions resulted in the child's death. The allegation of neglect to the child's sibling by the mother was determined to be founded as she failed to provide a safe living environment for them and later refused to provide for their care. The allegation of neglect to the child's sibling by the safety service provider was also determined to be founded as they had been arrested for shoplifting and in possession of methamphetamine while the child's sibling was present.

Description of relevant prior Department reports:

Date of report: June 30, 2014 **Assignment decision:** Within 24 hours	**Allegation(s):** Threat of Harm by the mother	**Disposition(s):** Founded

On June 30, 2014, ODHS received a report the child's sibling (6) had witnessed the mother slap a maternal relative, resulting in them falling backward and injuring their head. The relative told police they came home after receiving a call from their spouse reporting the mother was behaving erratically. When they arrived home the mother appeared to be under the influence of substances and was packing her and the child's sibling's

things, reporting they were leaving. The relative tried to speak with the mother, but she became combative and slapped them. An allegation of threat of harm by the mother to the child's sibling was assigned for CPS assessment with a 24-hour response time.

On July 1, 2014, the CPS caseworker interviewed a maternal relative who reported they and their spouse moved the mother and the child's sibling into their own home a few days prior but could not recall the address. On July 3, 2014, the CPS caseworker spoke with a police officer who stated the relative was not interested in pressing charges against the mother and stated they did not know where she and the child's sibling were residing. On July 9, 2014, the CPS caseworker spoke with a collateral contact who stated the mother reported relapsing on methamphetamine on June 23, and the contact was worried about the child's sibling's safety in the mother's care. On July 10,2014, the CPS caseworker again spoke with the collateral contact who reported the child's sibling was with their father in another city. On July 14, 2014, the collateral contact notified the CPS caseworker they located the child's sibling at the mother's home. The mother was being arrested for methamphetamine and heroin possession and the maternal relatives had been contacted to pick up the child's sibling. On July 18, 2014, the CPS caseworker met with the mother and offered her services. On September 9, 2014, a maternal relative contacted the CPS caseworker to report the mother and child's sibling moved to another city without notice. On September 10, 2014, the CPS caseworker spoke with the father of the child's sibling who agreed to pick the child's sibling up from the maternal relatives and take them to his home. Later in the day, the CPS caseworker had contact with the child's sibling at the home of the maternal relatives.

The allegation of threat of harm to the child's sibling by the mother was determined to be founded as the mother was using methamphetamine and heroin while caring for the child's sibling and substances and paraphernalia were found within close proximity to them. The mother had also assaulted a maternal relative in the child's sibling's presence and had not followed through with referrals for services to mitigate the threats her behavior presented to the child's sibling.

Date of report:	Allegation(s):	Disposition(s):
June 9, 2020	Threat of Harm by the mother's partner	Unable to Determine
Assignment decision:	Neglect by the mother's partner	Founded
Within 72 hours		

On June 9, 2020, ODHS received a report the mother had left the child's sibling (12) in the care of her partner a few weeks earlier while she went to the grocery store. The child's sibling called the mother to report the mother's partner had been in the bathroom for a long period of time and believed he was using methamphetamine. The mother returned home and asked her partner to complete a drug test, resulting in the partner seriously assaulting the mother. Since the incident, the mother reported living in her car due to fear her partner would show up at the home. The reporter did not know where the child's sibling was currently residing. Allegations of threat of harm and neglect by the mother's partner to the child's sibling were assigned for CPS assessment with a 72-hour response time.

On June 11, 2020, the CPS caseworker attempted to contact the mother and father by phone. The mother's voicemail box was full, and a message was left for the father. On June 15, 2020, the CPS caseworker spoke to the mother by phone. On June 17, 2020 a CPS caseworker met with the mother and child's sibling at their home. The mother reported being clean and sober but said in the past she had used methamphetamine in the child's sibling's presence and reported the child's sibling was aware what the substance was and how it made people behave. On August 20, 2020, the CPS caseworker spoke to the father by phone. He reported the child's sibling had been staying with him since mid-July and may remain in his care through the next school year. On August 26, 2020, the CPS caseworker attempted to call the mother's partner, but their voicemail box was full, and a message could not be left. On August 28, 2020, a courtesy caseworker had contact with the father at his home. On September 10, 2020, the CPS caseworker interviewed the child's sibling by phone. They stated they did not witness their mother's partner using methamphetamine on the day of the incident but observed them behaving erratically. When their mother returned home, she sent them to a neighbor's home. The child's sibling did not witness the mother being assaulted by her partner but

was aware the incident occurred. The child's sibling reported the mother's partner had not been to the home since the day of the incident.

The allegation of threat of harm to the child's sibling by the mother's partner was coded as unable to determine as they did not witness their mother being assaulted by her partner and did not witness their mother with any injuries. The allegation of neglect to the child's sibling by the mother's partner was determined to be founded as the child was in the partner's care while he was believed to be using methamphetamine.

Date of report: January 3, 2021 **Assignment decision:** Within 24 hours	**Allegation(s):** Threat of Harm by the mother's partner	**Disposition(s):** Founded

On January 3, 2021, ODHS received a report the mother's partner took the child's sibling (13) and their friend to run errands while he was wearing body armor and carrying a firearm. The mother became aware of what was occurring when she video chatted with him and he showed her the body armor and firearm, which the mother believed was done to intimidate her. The mother told her partner she no longer wanted to be in a relationship with him, resulting in him coming to her home and assaulting her before fleeing the scene. The mother's partner was said to be using methamphetamine and was a paranoid schizophrenic. The child's sibling and their friend were reported to be on their way to another city, where the friend resided. An allegation of threat of harm to the child's sibling by the mother's partner was assigned for CPS assessment with a 24-hour response time.

On January 4, 2021, the CPS caseworker attempted to contact the mother and child's sibling at their home, but there was no answer at the door. The CPS caseworker then attempted to call the mother, but her voicemail box was full, so they texted her asking for a return call. The CPS caseworker received information from a police officer that the mother had a swollen hand, bruising to her upper arm, was complaining of back pain, and said her partner had put his hands around her throat. The officer said the

mother was hesitant to provide details of the whereabouts of the child's sibling, but the officer did not believe they witnessed the incident. The mother told the officer she was concerned how ODHS may respond as she was currently in a custody dispute with the father of the child's sibling. On January 11 and 12, 2021, the CPS caseworker made additional efforts to contact the mother and child's sibling at home and by phone but was unsuccessful. On July 15, 2021, the father of the child's sibling contacted the CPS caseworker to report the child's sibling was staying with a friend of the mother due the mother relapsing on substances and facing eviction. Later in the day the caseworker spoke to the mother's friend who confirmed the mother had relapsed on methamphetamine and heroin and the child's sibling was with her. The mother's friend said the child's sibling had disclosed witnessing the mother being choked by her partner, had witnessed the mother's partner fire a gun in the home, and also reported the mother provided them with cigarettes, alcohol, and marijuana. On January 18, 2021, the father contacted the CPS caseworker and informed them he had picked up the child's sibling from the mother's friend. On January 27, 2021, a courtesy caseworker visited the child's sibling and their father at home. On January 28, 2021, the CPS caseworker attempted contact with the mother at home but there was no answer at the door. The mother's landlord confirmed a gunshot had been fired through the floor of the mother's apartment, into the apartment below. Prior to the completion of the assessment the CPS caseworker made several more unsuccessful attempts to contact the mother.

The allegation of threat of harm to the child's sibling by the mother's partner were determined to be founded as he forced the child's sibling to walk around for hours with him while he was wearing body armor and carried a rifle, had fired the rifle through the floor of the mother's home while the child's sibling was present, and choked the mother in the presence of the child's sibling. Allegations the mother had relapsed on substances while parenting the child's sibling and had provided the child's sibling with alcohol, marijuana, and cigarettes were reported to the Oregon Child Abuse Hotline and were assigned for a separate CPS assessment summarized below.

Date of report: January 25, 2021 **Assignment decision:** Within 72 hours	**Allegation(s):** Neglect by the mother and mother's partner	**Disposition(s):** Founded

On January 25, 2021, ODHS received a report the mother had provided the child's sibling (13) with marijuana, cigarettes, and alcohol and had coached them to report their father had sexually abused them. The child's sibling had witnessed their mother being assaulted by the mother's partner and had also witnessed the mother's partner discharge a firearm in the family's home. Allegations of neglect to the child's sibling by the mother and mother's partner were assigned for CPS assessment with a 72-hour response time.

On January 27, 2021, the CPS caseworker met with the child's sibling and their father at the father's home. The child's sibling disclosed that earlier in the month their mother's partner made them walk with them through downtown while he was carrying a rifle. The child's sibling reported feeling fearful and not safe during the incident. The child's sibling also disclosed there were always substances, including alcohol, sitting out on the living room table in the mother's apartment and the mother allowed them to drink alcohol and smoke marijuana. The mother's partner was reported to have made the child's sibling and their friend smoke marijuana dabs. The child's sibling stated there was often no food in her mother's apartment and said they would often go to the neighbor's apartments to ask for food. The child's sibling reported their mother had hit them in the past with a frying pan and a broom. The child's sibling said they woke up on January 4, 2021 to find the mother's partner had fired a gun in the apartment. They stated they did not witness the incident but saw the bullet hole. On January 28, 2021, a courtesy caseworker attempted contact with the mother at her apartment but there was no answer at the door. The mother's landlord reported there was a bullet hole in the floor of the mother's apartment and evidence the bullet traveled through the apartment below.

The allegations of neglect to the child's sibling by the mother and mother's partner were determined to be founded as the mother had provided the child with cigarettes, marijuana, and alcohol and the mother's partner made

the child's sibling walk with him through town while he was carrying a rifle and had fired a gun into the floor of the mother's apartment.

Date of report: May 23, 2022 **Assignment decision:** Within 24 hours	**Allegation(s):** Neglect by the mother	**Disposition(s):** Unfounded

On May 23, 2022, ODHS received a report the mother was leaving the child's sibling (14) home alone for extended periods of time. The mother and child's sibling were residing in a recovery home with other families, and children were not to be left unattended. The reporter stated the mother had been gone from the home for over 24 hours leaving the child's sibling unsupervised. When the reporter attempted to call the mother, the mother's partner answered the phone and handed it to the mother, who hung up on the reporter. The mother's partner was said to be using substances and was not allowed at the recovery home. The child's sibling told the reporter their mother was working out of town. An allegation of neglect by the mother to the child's sibling was assigned for CPS assessment with a 24-hour response time.

On May 24, 2022, the CPS caseworker attempted contact with the mother and the child's sibling at home. There was no answer at the door and a card requesting a call back was left. The CPS caseworker spoke with the mother's house manager who stated the mother worked for a flagging company and had left the child's sibling home alone for the past two days. The family was in the process of being evicted from the home for not following house rules. The CPS caseworker left a voicemail for the mother and then contacted the father by phone. The father was willing to come pick up the child's sibling if necessary. On May 25, 2022, the CPS caseworker met with the child's sibling at school. The child's sibling acknowledged the mother's past history of substance use but stated they did not believe their mother was currently using substances. The child's sibling said their mother worked long hours and had a service dog that was not allowed in the recovery home. When asked when the last time was they had seen their mother, the child's sibling said they met her at the park the

previous evening. The CPS caseworker then visited the mother's partner at the recreational vehicle park he and the mother were residing at. The mother's partner presented as being under the influence of substances and stated the mother was at work. The CPS caseworker spoke with the mother's house manager who reported the child's sibling needed to move out of the recovery home the following day. The CPS caseworker then spoke to the mother by phone. She stated she would bring the child's sibling to stay with her and her partner at their RV that evening. On May 27, 2022, the CPS caseworker met with the child's sibling at school. They reported staying with the mother and her partner at the RV. The child's sibling stated the mother's partner was using substances and had anger problems but denied any physical altercations between the mother and her partner were occurring. On May 30, 2022, the CPS caseworker met with the mother and child's sibling at the RV and no safety concerns were observed. During the course of the assessment the CPS caseworker received information confirming the mother was not using substances. On June 14, 2022, the CPS caseworker texted the mother a list of housing and counseling resources.

The allegation of neglect to the child's sibling by the mother was determined to be unfounded as the child's sibling was not fearful and had all of their needs met while they were home alone, was aware of the mother's whereabouts at all times, had frequent contact with the mother by phone, and the mother was residing in an RV just a few blocks from the recovery home the child's sibling had been staying in before joining the mother and her partner in the RV.

Date of report: January 10, 2023 **Assignment decision:** Within 24 hours	**Allegation(s):** Physical Abuse by the mother	**Disposition(s):** Unable to Determine

On January 10, 2023, ODHS received a report the mother and the child's sibling (15) became involved in a physical altercation over the winter school break. During the altercation the mother was said to have hit and kicked the

child's sibling as well as grabbed them by their ear piercing causing their ear to bleed. An allegation of physical abuse by the mother to the child's sibling was assigned for CPS assessment with a 24-hour response time.

On January 11, 2023, the CPS caseworker interviewed the child's sibling at school. They disclosed being physically assaulted by the mother on January 2 after they told their mother they hated her. The child's sibling reported being pushed against a wall and headbutted by the mother. They said they had a small bump on their head and blood around their ear piercing after the incident, but the CPS caseworker did not observe any injuries to the child's sibling on the day of the interview. The child's sibling said they lived with their mother and mother's partner at the home of a roommate who recently moved out. The roommate was the lease holder of the apartment, and they were now facing eviction. The child's sibling said the mother and her partner were using blue pills they smoked from a straw off of tin foil. The CPS caseworker then went to the mother's home and encountered the apartment manager outside. The apartment manager said the mother and child's sibling were not on the lease to the apartment and since the lease holder had recently moved out, everyone was being evicted. The apartment manager reported a high volume of traffic in and out of the home by people suspected to be using substances. On January 12, 2023, the CPS caseworker left a voicemail for the mother and attempted to contact the father but the contact information for him was incorrect. On January 19, 2023, the CPS caseworker left another voicemail for the mother then attempted contact with her at home. There was no answer at the door and a card was left for her. On January 24, 2023, the CPS caseworker left another voicemail for the mother then requested an Accurint search for the parents in an effort to gather updated contact information. The search resulted in the same addresses the CPS caseworker already had for the parents and the phone numbers obtained through the search were incorrect.

The allegation of physical abuse by the mother to the child was coded as unable to determine as the child did not have any physical injuries and the mother was unable to be interviewed regarding the allegation.

Date of report: May 30, 2023 **Assignment decision:** Within 72 hours	**Allegation(s):** Neglect by the mother	**Disposition(s):** Unable to Locate

On May 30, 2023, ODHS received a report the mother was driving a stolen vehicle, accompanied by the child's sibling (15), when she was pulled over by law enforcement. Fentanyl pills, two containers of fentanyl powder, a scale, drug paraphernalia, Narcan, a handcuff key, and a gun magazine were found in the car. The mother was arrested and did not appear to be under the influence at the time. The child's sibling was reported to have been shaken up after being ordered out of the car at gun point. Police made efforts to find a family member or friend to pick up the child's sibling and when they were unsuccessful, they transported them home. An allegation of neglect to the child's sibling by the mother was assigned for CPS assessment with a 72-hour response time.

On June 1, 2023, the CPS caseworker checked the rosters at local jails and found no records for the mother. The CPS caseworker then made multiple unsuccessful attempts to check if the child's sibling was enrolled in school. On June 2, 2023, the child's sibling's school reported they were dropped from enrollment after missing 10 consecutive days of school. On June 3, the CPS caseworker attempted contact with the mother and child's sibling at home. There was no answer at the door and a contact card was left for the mother. The CPS caseworker attempted to call the mother by phone, but the number was no longer in service. The CPS caseworker made three more unsuccessful attempts to contact the mother and the child's sibling at home between June 5 and June 19, 2023. On June 20, 2023, the CPS caseworker spoke with the child's therapist who reported having no recent contact with the family. The child's sibling's school had told the therapist the child's sibling had been expelled from one school then was disenrolled from another for lack of attendance. On June 22, 2023, the CPS caseworker mailed the mother a letter requesting she contact them. Later in the day, the CPS caseworker made efforts to find alternative contact information for the family. On June 24, 2023, an Accurint search located no new contact information for the family. The CPS caseworker made multiple attempts to contact a CPS caseworker in another branch

who also had an open CPS assessment on a family the child's sibling was reported to be residing with but never received a response. On June 25, 2023, the CPS caseworker left a voicemail for a person the child was believed to be residing with.

The allegation of neglect by the mother to the child's sibling was not able to be determined as the family was not able to be located. There is no documentation in the assessment the CPS caseworker made efforts to contact the father.

Date of report: September 14, 2023 **Assignment decision:** Within 72 hours	**Allegation(s):** Neglect by the mother	**Disposition(s):** Unable to Determine

On September 14, 2023, ODHS received a report the child's sibling (15) was residing with their partner and partner's family after being asked to leave their mother's home approximately two weeks prior. The child's sibling's partner's family had an open ODHS case at the time and the children had just been placed into their father's care. The child's sibling was said to be fearful of returning to their mother's home due to her methamphetamine use. An allegation of neglect by the mother to the child's sibling was assigned for CPS assessment with a 72-hour response time.

On September 17, 2023, the CPS caseworker attempted contact with the child's sibling at the home of their partner's family, but no one was at home. On September 24, 2023, the CPS caseworker met with the child's sibling at her partner's home. The child's sibling reported their mother had kicked them out of their home and had thrown their belongings outside. They stated their mother was using substances and had prioritized her relationship with her partner over the child's sibling's needs.

On September 30, 2023, ODHS received an additional report of concern for the child's sibling resulting in new allegations of neglect by the mother and threat of harm by the mother's partner and were assessed concurrently with the allegation made on September 14, 2023. A summary of the assessment of the September 30, 2023 allegations is below.

The allegation of neglect by the mother to the child's sibling was coded as unable to determine as the child's sibling's disclosures were not able to be corroborated. The mother was not able to be located during the course of the assessment and the child's sibling would not provide updated contact information for her.

Date of report: September 30, 2023 **Assignment decision:** Within 24 hours	**Allegation(s):** Neglect by the mother Threat of Harm by the mother's partner	**Disposition(s):** Unable to Determine

On September 30, 2023, ODHS received a report the mother had relapsed on substances and was using fentanyl and methamphetamine daily. Drug paraphernalia was said to be out in the open in the mother's bedroom. The reporter stated domestic violence was occurring between the mother and her partner and in March 2023 the child's sibling witnessed the mother's partner with his hands around their mother's neck after hearing the mother scream for her partner to get off of her and that she could not breathe. The child's sibling had reportedly run away from the mother's home due to what was occurring. Allegations of neglect by the mother to the child's sibling and threat of harm by the mother's partner to the child's sibling were assigned for CPS assessment with a 24-hour response time.

On September 30, 2023, the CPS caseworker attempted contact with the mother at her home. There was no answer at the door and a card was left for the mother. The child's sibling was residing with their partner's family who had an open ODHS case. A review of the case revealed recent founded allegations of neglect and threat of harm by the father of the child's sibling's partner and also noted he had pending felony charges against him. The CPS caseworker then met with the child's sibling at their partner's home. The child's sibling was asked if they would be willing to go to a resource home, shelter, or hotel if it were determined they were unsafe at their partner's home and the child's sibling responded they were not willing to leave their partner's home that day but were willing to consider another living arrangement in the future. The CPS caseworker staffed the situation with their supervisor, and it was determined ODHS would not intervene

since the child's sibling reported feeling safe in their partner's home. The CPS caseworker spoke by phone with the father of the child's sibling's partner who stated the child's sibling had returned home to their mother for a few days then contacted the partner's father to pick them back up, saying they did not feel safe in the mother's home. The partner's father said the child's sibling had pictures on their phone of the substances being used in the mother's home.

On December 11, 2023, the CPS caseworker spoke with an individual who reported the child's sibling was currently residing with them. They said they were an acquaintance of the father of the child's partner which is how they met the child's sibling. The individual stated they had been a safety service provider for the child's sibling's partner's family in the past. The CPS caseworker noted this individual had a felony record as did their relative who also resided in the home. The CPS caseworker then attempted to call the mother and was told by the person answering the phone it was a wrong number. The CPS caseworker spoke with the father of the child's sibling who reported the child's sibling had recently stayed with his family for a short time before being picked up by the individual they were currently living with. He reported the child's sibling did not like the rules in his home and said he was concerned for their mental health and well-being.

On February 7, 2024, the CPS caseworker attempted contact with the child's sibling at the home they were reported to be residing at in December, but no one answered the door. On March 4, 2024, the CPS caseworker met with the child's sibling who was still living with same individual they had been with since December. The child's sibling reported their mother knew where they were living and said they occasionally spoke with her through social media but were unwilling to provide any contact information for their mother. No concerns were observed for the safety and well-being of the child's sibling in the home where they were residing.

The allegations of neglect to the child's sibling by the mother and threat of harm to the child's sibling by the mother's partner were coded as unable to determine as the mother and her partner were not able to be located during the course of the assessment to respond to the allegations.

Date of report: September 2, 2024 **Assignment decision:** Within 72 hours	**Allegation(s):** Threat of Harm by the mother	**Disposition(s):** Unfounded

On September 2, 2024, ODHS received a report the mother tested positive for amphetamines, fentanyl, methadone, and oxycodone upon giving birth to the child two days earlier. The mother was said to be making efforts to address her substance use through services. The child was initially placed in the Neonatal Intensive Care Unit (NICU) due to breathing issues but was currently with the mother and it was reported the mother and child would be released the following day. An allegation of threat of harm by the mother to the child was assigned for CPS assessment with a response time of within 72 hours.

On September 3, 2024, the CPS caseworker spoke to a social worker at the hospital who stated the mother and child were not ready to be discharged as the child had experienced a drop in weight. The CPS caseworker, accompanied by a coworker, met with the mother, child and the child's sibling (16) at the hospital. The mother stated she was not certain who the child's father was and said the two possible fathers were both incarcerated and she did not want either of them to be involved in the child's life. The mother stated she was enrolled in services to address her substance use but still using fentanyl daily. She denied using methamphetamine in over a month and suspected she had tested positive for it due to her fentanyl being laced with it. The mother also disclosed using marijuana. On September 4, 2024, the CPS caseworker spoke with a collateral contact who stated the mother had been making efforts to address her substance use since she found she was pregnant with the child. The CPS caseworker then spoke with a social worker at the hospital who reported the mother was discharging that day, but the child would be transferred to children's hospital due to issues with their weight. The weight issues were said to not be related to in-utero substance exposure. On September 5, 2024, the CPS caseworker met with the mother at her home. No safety concerns were observed, the mother showed the CPS caseworker the bassinet where the child would be sleeping, and the CPS

caseworker discussed safe sleep practices with her. The CPS caseworker submitted a referral for services for the mother, then spoke by phone with a friend of the mother that had been identified as a potential safety service provider. On September 6, 2024, the CPS caseworker attended a safety and sustainability meeting on the case, then spoke with a social worker at the children's hospital who confirmed the child had been transferred there. The CPS caseworker spoke to the mother's friend who stated they worked Wednesday through Friday from 2 p.m. to 10 p.m. but were available all other hours to be a safety service provider. On September 7 and 9, 2024, the CPS caseworker received text messages from the mother's friend who reported their employment status had changed, and they were now available to be a safety service provider around the clock. The CPS caseworker spoke with a social worker at the children's hospital who reported the child's release date was still undetermined. On September 11, 2024, the CPS caseworker was notified the child would be discharged later in the day and the mother and the safety service provider would be coming to the hospital to be trained on changing their feeding tubes before they were released. On September 12, 2024, the CPS caseworker visited the mother, the child, and the safety service provider at the mother's home. The child had an NG (nasogastric tube used for feeding) tube and both the mother, and the safety service provider said they were trained to change it. On September 13, 2024, the CPS caseworker requested information from a service provider supporting the mother. On September 25, 2024, the CPS caseworker and the newly assigned permanency caseworker visited with the mother, the child, and the safety service provider at the mother's home. The home was noted to be significantly cleaner than in prior visits and the mother explained her former partner's possessions had been moved out. On October 8, the CPS caseworker spoke by phone with a collateral contact who reported the mother was actively engaged in efforts to support her sobriety.

The allegation of threat of harm by the mother to the child was determined to be unfounded as she was engaged in services, was observed to be providing appropriate care to the child and had agreed to cooperate with ODHS safety planning.

Level 3 - Restricted

Date of report: November 20, 2024 **Assignment decision:** Within 24 hours	**Allegation(s):** Physical Abuse by the mother's partner	**Disposition(s):** Founded

On November 20, 2024, ODHS received a report the child's sibling (16) had been injured during a physical altercation with the mother's partner. The reporter stated the mother's partner had gone to the mother's home to pick up some of his possessions. When he arrived, the mother was not at home. The child's sibling and the safety service provider were at the residence and tried to prevent the mother's partner from entering by pushing the front door closed. During the altercation, the mother's partner bent the child's sibling's finger backwards resulting in swelling. The mother's partner fled the home after the child's sibling told him they would be contacting law enforcement. The mother and the safety service provider later took the child's sibling to the hospital for an X-ray. The mother's partner was reported to have a history of violence against women and was suspected to be the father of the child. An allegation of physical abuse to the child's sibling by the mother's partner was assigned for CPS assessment with a 24-hour response time.

On November 21, 2024, the CPS caseworker contacted the hospital and learned child's sibling had been discharged the previous day. It was determined their finger was not broken but was sprained. Child's sibling's school was contacted, and they reported they were not present that day. The CPS caseworker attempted contact with the family at home but there was no answer at the door and a card was left for the mother. The CPS caseworker attempted to contact the mother and the safety service provider by phone but was unsuccessful. The permanency caseworker provided the CPS caseworker with updated contact information for the mother and safety service provider and stated they had been provided with a hotel voucher for two nights which was why they were not at home. The CPS caseworker left messages for the mother and safety service provider requesting a call back.

On November 22, 2024, the CPS caseworker contacted child's sibling's school again and they reported they were not present. On November 26,

2024, the CPS caseworker made an unscheduled home visit and spoke with the mother and safety service provider. The child's sibling was reported to be out of town for Thanksgiving and would be returning in a few days. The child was observed to be sleeping. The mother said she was not at home and was driving home from work when the incident occurred. She said after the incident, her partner texted her a picture of a bruise on his face which he said was the result of the child's sibling punching him. On December 2, 2024, the child's sibling exchanged text messages with the CPS caseworker and agreed to be interviewed about the incident.

On December 12, 2024, the CPS caseworker and permanency caseworker met with the family at home. The permanency caseworker had recently received information the mother may be using fentanyl. The mother denied using fentanyl since the child's birth. The permanency caseworker spoke with the safety service provider regarding concerns they were difficult to contact and may need to be replaced as a safety service provider if they continued to be unreliable. The mother and the child's sibling provided the caseworkers with new phone numbers. The safety service provider reported no longer having a phone and the permanency caseworker agreed to provide them with a new one.

On December 13, 2024, a safety and sustainability staffing was held on the case. It was decided to ask the mother to complete a urinalysis (UA) with an ODHS approved provider and to also have the child complete a UA. The permanency caseworker was asked to make an In-Home Safety and Reunification Service (ISRS) referral for twice weekly visits and to update the ongoing safety plan to include clear guidance for the safety service provider on what to do if they had concerns for the child's safety or that the mother was using substances.

On December 16, 2024, the CPS caseworker visited the home and had contact with the mother, the safety service provider, the child, and the child's sibling. The child's sibling told the CPS caseworker their mother's partner had hit the mother and had taken an apartment key without permission on the day prior to the incident. On the following day he used the key to enter the apartment despite being told in the past he needed the mother's permission to enter the home. The child's sibling said she told the mother's partner they were going to call the police. He responded by saying

he needed to get a car tire from inside the home, and the child's sibling told him he could not do so while the mother was not home. The child's sibling said the mother's partner then shoved them, causing the child's sibling to fall on to a crate and hurt their back. When the mother's partner put his hands on the child's sibling, they punched him in the face giving him a black eye. A tug of war over the tire ensued. The safety service provider was trying to control the dogs in the home during the altercation and at one point the mother's partner pushed them causing one of the dogs to bite him and accidentally bite the safety service provider as well. After the mother's partner left the apartment with the tire, the child's sibling called the police. The child's sibling reported injuring their finger and receiving a bruise on their back during the altercation. When asked where the child was during the incident, the child's sibling stated they were asleep in the bedroom. The CPS caseworker requested contact information for the mother's partner from the mother. The safety service provider said they were very proud of the mother for addressing her substance use upon learning she was pregnant with the child. The safety service provider shared their frustration with ODHS' expectations they answer phone in what the permanency caseworker considered a reasonable amount of time. The safety service provider gave an example, saying that the permanency caseworker called while the family was Christmas shopping and expected a call back immediately. The safety service provider stated they felt as if they did not answer the phone right away they would be seen as uncooperative, and the children could be removed from the mother's care. On December 31, 2024, the CPS caseworker spoke with the father of the child's sibling by phone. He reported seeing the child's sibling only once or twice per year in the past six years.

Between December 20, 2024, and January 10, 2025, the CPS caseworker made numerous attempts to contact the mother's partner by phone and by mail, and eventually made phone contact with him on January 10, 2025. He stated that a few days prior to the incident he had been in an argument with the mother and left his possessions, including two tires, in her home. When a person became interested in buying the tires, the mother's partner said he made multiple attempts to contact the mother, but she did not respond to his calls. He stated when he went to the home he tried to explain to the child's sibling and the safety service provider he just wanted his tires, but

the child's sibling threatened to call the police. At that point, the mother's partner said he decided to just go get his tires and leave the home. The mother's partner said the safety service provider stepped into his way, and he nudged them aside, resulting in the child's sibling stepping forward and punching him in the face. When he grabbed his tires, he said the child's sibling tried to pull them out of his hands, so he jerked them away and the child's sibling punched him in the face several more times until the safety service provider told them to stop. He denied ever touching the child's sibling during the incident.

The allegation of physical abuse to the child's sibling by the mother's partner was determined to be founded as he entered the home without permission and shoved the child's sibling resulting in them injuring their back then jerked the tires from their hands causing an injury to one of their fingers.

Date of report: January 6, 2025 **Assignment decision:** Within 24 hours	**Allegation(s):** Neglect by the mother	**Disposition(s):** Unfounded

On January 6, 2025, ODHS received a report the mother was using fentanyl in the home she shared with the child (4 months), the child's sibling (17), and a roommate. The reporter stated the mother was observed two days earlier using a needle to inject fentanyl while in her kitchen. The mother and her roommate were said to be nodding off at all times of day while caring for the child. It was further reported the mother would leave the child in the care of the child's sibling while she would go out at all hours looking for fentanyl. The child's sibling would repeatedly call the mother who would not answer. When the mother was confronted about her fentanyl use, she stated it was not a problem as she only used it in the kitchen, where the child did not go. Allegations of neglect to the child and child's sibling by the mother were assigned for CPS assessment with a 24-hour response time.

On the day the report was made the CPS caseworker, who had been working with the family since November 2024, e-mailed the Oregon Child

Abuse Hotline (ORCAH) feedback e-mail box in an effort to have the assignment decision changed to closed at screening. The CPS caseworker explained that themself, the permanency caseworker, the permanency supervisor and other CPS and permanency caseworkers had all made visits to the home and had not observed any signs the mother was using substances. The CPS caseworker stated the mother had recently completed a UA and the results were not concerning and also stated the child had a UA that was negative for substances. It was also stated the child's sibling as well as a service provider for the mother had no concerns she was using fentanyl. The CPS caseworker questioned the motivations of the anonymous reporter and challenged the information the mother was using fentanyl intravenously when smoking it was much more common method of use. A lead continuous quality improvement worker for ORCAH responded that after reviewing the report and the information the CPS caseworker provided, they still supported the decision to assign the allegations for assessment.

Later, on January 6, 2025, the CPS caseworker attempted to contact the family at home, but there was no answer at the door. They texted the child's sibling who responded they were not at home and left a voicemail for the mother. On January 7, 2025, the CPS caseworker spoke to mother who agreed to complete a UA that day. She was provided with the address of the lab and was asked to arrive there no later than 4:30 p.m. On January 9, 2025, the CPS caseworker received information the mother had not shown up for her UA appointment. Later that day, the CPS caseworker and a co-worker visited the family at home. The mother, the safety service provider, and the child's sibling all denied the information in the report. The mother said she missed her UA due to being busy with other appointments and she agreed to UA the following day. The CPS caseworker asked the safety service provider if the phone ODHS provided for them was still working as the permanency caseworker reported having problems contacting them. The safety service provider reported the phone was no longer working and gave the CPS caseworker a new phone number. No concerns were observed for the safety of the children. The CPS caseworker scheduled a new appointment for the mother to UA on the following day. On January 13, 2025, the CPS caseworker received information the mother was a no show for her UA appointment. On the

following day the CPS caseworker texted the mother to ask about her missed appointment. The mother replied on January 14, 2025, stating she had been very ill but was feeling better. On January 16, 2025, the CPS caseworker staffed the case with their supervisor who asked another appointment to be set up for the mother to UA and expressed concern about the two prior missed appointments and the mother not notifying ODHS she had missed them. The CPS caseworker texted the mother, who agreed to UA the following day. On January 21, 2025, the CPS caseworker received notification the mother had missed her most recent UA appointment as well. The CPS caseworker then texted the mother to inquire why she did not make it to the appointment and did not notify ODHS she had missed it.

On January 24, 2025, the CPS caseworker received an e-mail update from the permanency caseworker that the mother was not at home for a scheduled home visit on the previous day. The permanency caseworker called the mother, who did not respond. The permanency worker then contacted the safety service provider who reported they were at a grocery store and their vehicle would not start. The safety service provider said the child was in their care and the mother was inside the store, but her phone battery was dead. The permanency caseworker asked the safety service provider to have the mother call them when they got home. After an hour there was no response, so the permanency caseworker called the safety service provider again, but they did not answer. The permanency caseworker also reported the ISRS (In-Home Safety and Reunification Services) provider had finally contacted the family the previous evening after trying for weeks. Later the permanency supervisor emailed the CPS caseworker to inform them the permanency caseworker had contact with the family at home. The child's sibling said they did not have any concerns their mother or the safety service provider were using substances. It was noted the mother did not appear as if she were using substances based on her behavior and appearance and no concerns were observed after a walk-through of the home. The mother agreed to let the permanency caseworker take her in for a UA on January 27, 2025. The mother did not make it to her UA appointment with an ODHS approved lab on January 27, 2025 but did provide an unsupervised UA at an urgent care office. On January 30, 2025 the CPS caseworker received a screenshot of the mother's UA results the

mother had taken from her MyChart account. The results were positive for cannabinoids and negative for all other tested substances.

On January 30, 2025, a case staffing was held where it was noted the mother had missed four appointments to UA but had recently completed a UA which was described as negative (despite the positive result for cannabinoids). It was also noted that ODHS staff, collateral contacts, and the safety service provider all reported no concerns the mother was using substances. It was determined the CPS assessment would be completed with an unfounded disposition and the safety plan would be modified to decrease the level of supervision by the safety service provider from 24/7 to three times a week check-ins.

The allegations of neglect to the child and child's sibling by the mother were determined to be unfounded as at the conclusion of the assessment there was no information gathered that she was using substances or failing to meet the needs of her children. This assessment was open at the time of 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 expressed reservation about the in-home criteria[1] being consistently met throughout periods of the ongoing case. Primarily, concern centered around the parent's limited cooperation in support of the in-home safety plan along with communication barriers between the safety service provider and ODHS. Lack of ongoing evaluation of the in-home safety plan criteria combined with difficulty understanding parental substance use raised concerns about the adequacy of child safety management.

In addition, a service provider for the mother was not responsive to ODHS requests for records and updates regarding the mother's engagement and progress in the service. As a result, ODHS could not consider the mother's involvement in the service as a factor contributing to improved child safety. Additionally, communication barriers emerged between an in-home service

[1] OAR 413-015-0432(2)(c)(B)

provider and the mother, who was unresponsive to their attempts to contact her, ultimately delaying the start of in-home services.

The CIRT also discussed a lack of consistency in addressing and monitoring safe sleep practices during permanency case management. While extensive work has been done to train the child welfare workforce and provide tools, consultation and other resources geared towards education, permanency fidelity reviews in 2024 indicate there is a need for improvement in assessing and documenting safe sleep during ongoing case management.

The CIRT noted the father of the child's sibling was often not contacted or contacted in a timely manner when ODHS had concerns for the sibling's safety. Oregon administrative rule[2] outlines requirements for contacting non-custodial legal parents that must be followed during the course of a CPS assessment and ongoing case management activities.

Lastly, the CIRT highlighted concerns regarding the impact of parental marijuana use on child safety, particularly when a parent under the influence shares a sleep surface with an infant. The effects of legal substances such as marijuana, alcohol, and prescription medications may be underestimated in child safety assessments and ongoing case management, despite evidence indicating that these substances can significantly impair parental functioning and the ability to provide safe and responsive care when the infant is both awake and asleep. In this case, the mother reported regular marijuana use; however, the potential implications for her daily functioning and the safety of the child did not appear to be adequately considered or explored.

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 CIRT recommends the local Permanency and Safety consultants develop a coaching plan that aids in reinforcing existing procedures and OAR regarding the following: in-home criteria, assessment of an individual as a safety service provider, realistic expectations for safety services when

[2] OAR 413-015-0420 (3)(b)(D)

24/7 safety plans are necessary, timely contact with non-custodial legal parents and steps to take when an in-home plan is no longer viable. Guidance should also be provided when a parent's participation in a service can be considered a safety activity, especially in cases where there are communication barriers with the service provider. The development of this plan should begin no later than June 30, 2025.

The CIRT recommends the Child Reunification Program conduct a statewide review of cooperative in-home safety plans involving children under 12 months of age. The purpose of this review is to identify opportunities to enhance how safe sleep practices are addressed both in ongoing safety plans and during face-to-face interactions with families. Following the completion of this review, the Child Reunification Program will develop and implement a comprehensive strategy to support local offices in strengthening practice and documentation related to safe sleep, and in ensuring that appropriate and effective safety plans are in place. This review should begin no later than July 31, 2025.

Local office child welfare staff including caseworkers, supervisors, consultants, Coaching and Training Specialists, and Recovery Support Team leads, will complete Safe Sleep training if they have not previously completed the training prior to May 1, 2025. Local office leadership will establish a timeline for completion and implement a plan to monitor participation.

This case, like others reviewed by the CIRT, highlights the challenges faced by the child welfare workforce in understanding substance use disorder as a chronic disease that requires ongoing, effective treatment interventions for managing substance use disorder and promoting recovery. It also highlights the need to seek and incorporate expert guidance to assist in understanding parental behaviors that may be indicative of a parent experiencing relapse. The CIRT recommends that Recovery Support Team (RST) leads be actively involved from the onset of a CPS assessment. Their expertise in parental substance use disorder (SUD) is invaluable and should be leveraged whenever indicators of substance use are identified. This engagement will deepen the understanding of parental substance use and its effects on child safety and family well-being.

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To facilitate this, the SUD Prevention Coordinator will work closely with local CPS and Permanency Supervisors, as well as RSTs, to develop a structured plan for increasing RST involvement with parents and caregivers. This collaboration will commence no later than August 1, 2025.

Safe systems analysis of cases involving child fatalities in the local district identified bias in safety decision making as an area for improvement and the local district has partnered with the Office of Equity and Multicultural Services to develop a training on bias that will be implemented in May 2025.