Critical Incident Review Team Final Report

A Critical Incident Review Team is convened by the Oregon Department of Human Services (ODHS) 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).

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><th colspan="3">CIRT ID: V7A1ZPU8MF</th></tr>
<tr><td>Date of critical incident:

January 22, 2025</td><td colspan="2">Date Department became aware of the fatality:

January 22, 2025</td></tr>
<tr><td>Date Department caused an investigation to be made:

January 22, 2025</td><td colspan="2">Date of child protective services (CPS) assessment disposition:

April 4, 2025</td></tr>
<tr><td>Date CIRT assigned:

January 30, 2025</td><td colspan="2">Date Final Report submitted:

May 9, 2025</td></tr>
<tr><td>Date of CIRT meetings:

April 4, 2025</td><td>Number of participants:

13</td><td>Members of the public?

No</td></tr>
</table>

Level 3 - Restricted

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

Date of report:	Allegation(s):	Disposition(s):
January 22, 2025 **Assignment decision:** 10-days	Neglect by the mother	Founded

ODHS received a report on January 22, 2025, alleging neglect to the child, who was two months old, by their mother. The reporter stated that the child was found deceased in the mother's home around 5:30 a.m. on the day of the report. The reporter did not have significant information about the circumstances of the fatality but offered that the death occurred while the mother and her significant other were sharing a sleeping surface with the child. The child was said to have had a kidney condition which was being monitored by a local medical specialist. There was concern that the mother used marijuana but had no information on the extent of use or how it may have impacted her ability to parent. The father's whereabouts was unknown to the reporter. There were no other children or adults in the home at the time of the critical incident.

The Child Protective Services (CPS) caseworker attempted face-to-face contact with the mother on January 27, 2025, which was unsuccessful. The caseworker met with the mother on January 29, 2025, at her home.

The mother reported that she had been in an on-and-off-again relationship since 2021 with her significant other, who is not the father of the deceased child. The deceased child had a sibling through the child's father. She identified the father and indicated he was present for the child's birth but otherwise had not provided any care to the child. Her significant other had been with her during her pregnancy and was a caregiver to the child. The significant other has their own residence but stayed with the mother most of the time. When the child was discharged from the hospital, they went to live with the significant other's family for two weeks for support, because this was her first child.

The mother reported using THC via vape pen and smoking cannabis flower by bong throughout the day prior to her pregnancy. When she learned she was pregnant, she reported smoking one bowl of flower in the morning to alleviate nausea, motion sickness during car rides and for appetite. She said her OB/GYN provider was aware of her use during pregnancy. After the child was born, the mother would smoke one-to-two bowls of flower, but not on a daily basis.

Instead of breastfeeding, the mother would pump about an hour before the child needed to eat and then provide it via bottle when needed. The caseworker asked if she tested the milk supply, to which she replied that she was not aware of that process. When asked about nighttime routine, the mother said she would change the child's diaper, provide a nighttime bottle and then go to bed.

On the evening prior to the critical incident, the mother said she fed the child a bottle and they fell asleep on her chest while burping them which she believed was around 8 p.m. She laid the child down on their back in the queen-size bed with her significant other so she could get ready for bed herself.

The mother then smoked one-to-two bowls of flower, brushed her teeth and laid down in bed with the child and her significant other. She laid in the middle of the bed between the two, as the significant other would often toss and turn in their sleep, and she did not want them to roll on top of the child. She said that the child was often hard to console in the evenings, and she would leave the child with her significant other in order to go outside and smoke flower to calm her nerves, which was the situation on this evening.

The mother told the caseworker that she woke up sometime around 2 a.m. to 2:30 a.m. and checked on the child. She did not know why she woke up but quickly realized that she hadn't heard the child crying that they were hungry. When she noticed the child was not moving, she turned on the light on her phone to see better. She observed that the child had rolled to their stomach. Their chest did not rise, their skin was cold to the touch, and they had blood near their nose and mouth. She screamed and turned on the light in the room. She reported that she "froze," and did not know what to do. Her significant other told her to call 9-1-1, and the significant other performed CPR on the child until emergency medical services (EMS) and

the local Law Enforcement Agency (LEA) arrived. She told the caseworker that she knew she needed to put the child in their bassinet in the room and shouldn't have had the child in bed with them. She added that she just wanted them close by.

LEA and medical records show some inconsistencies in the report she provided to the caseworker. The mother initially told LEA officers that she did not believe she laid on the child but later posited that she may have rolled over the child. The mother told LEA officers that sharing a sleeping surface was a regular practice in their home. LEA officers did not observe any apparent injuries to the child. The home environment was cluttered but not dirty. Officers had begun clearing a path for EMS personnel to enter the home upon responding to the incident, but EMS instructed an officer to bring the child out to them instead.

The significant other provided statements to LEA officers, which generally aligned with the mother's report of events. The significant other noted that the child was particularly fussy on the evening prior to the critical incident, but nothing else was outside the typical nighttime routine. The significant other estimated that the mother came to bed around 8:45 p.m. They also noted that the child had cried a couple of times before the mother observed that they were unresponsive. LEA officers asked if they knew what time they observed the child crying, but they did not because they did not have a clock. LEA records indicated that the mother's ability to recall events and sense of time was poor, which was unknown if this was due to the trauma involved with this incident, or if her use of marijuana impaired her alertness and awareness.

Additionally, during the search of the home, LEA discovered a small, round multicolored rubber container which contained crystalline residue in it. LEA conducted a field test on the substance, which showed a presumptive positive for methamphetamine.

Medical records indicated that the child was small for their gestational age at birth, which may have been affected by maternal cannabis use in utero. After birth, the mother was observed to be attentive and responsive of the child. In later appointments, the mother was concerned for the child's feeding, but they gained weight and were within the typical growth parameters. The child experienced jaundice which was treated with vitamin

D drops. The child had swollen kidneys, but the mother had taken the child to all appointments regarding this and scheduled an ultrasound which would have occurred after the critical incident. Posthumous medical provider consultation yielded questions about the timeline of events provided by the parents. The child had a full stomach at the time of death, combined with fixed lividity of settled blood. This led the medical provider to believe that the child likely died earlier in the night, estimated around 10 p.m. Based on posthumous presentation, the provider believed the mother likely rolled over while asleep, causing the child to roll over themselves.

The caseworker spoke to the significant other via phone on March 4, 2025. They indicated that they were no longer in a relationship with the mother and declined an interview because they had already participated in an interview with LEA.

The caseworker attempted to contact the father multiple times throughout the CPS assessment, beginning on January 29, 2025. The father was not listed on the child's birth certificate, and the caseworker sent a non-custodial letter to their last-known address. The father was located in March 2025 at the local jail; their attorney declined interviews for the CPS assessment.

The sibling was involved in a CPS assessment which was reported on March 19, 2025, which is not fully summarized here as it occurred after the critical incident. It is relevant to the critical incident, however, as the sibling's mother had moved into the mother's home along with the sibling. The report alleged that drugs and associated paraphernalia – namely cannabis and cocaine – were observed in the home. It also raised concern that the sibling's mother was seen blowing marijuana smoke with the sibling nearby.

The allegation of neglect of the child by their mother was coded as founded. Based on information gathered, beyond the decision to share a sleeping surface with the child, it was reasonable to believe that the mother's THC use impacted her ability to respond to the child's needs.

Description of relevant Department history regarding the sibling:

Date of report: August 23, 2024 **Assignment decision:** 24 Hours	**Allegation(s):** Threat of Harm by the father	**Disposition(s):** Unable to Locate

ODHS received a report alleging threat of harm to the child's sibling, who was a newborn, by their father. The reporter stated that the local law enforcement agency (LEA) had arrested the father in relation to an incident in which they allegedly assaulted an unrelated adult. When LEA first attempted contact with the father at the home where he was registered as a sex offender, it was noted that he moved out of that residence to live with their significant other, the sibling's mother. The reporter said that a relative, who owned the home where the mother lived, may not have known that the father was registered as a sex offender.

The CPS caseworker attempted face-to-face contact with the sibling and their mother at the hospital on August 23, 2024, but they had been discharged from the facility. On the same day, the caseworker attempted contact at the listed addresses for the family but was unsuccessful in contacting the parents. The caseworker continued efforts at unannounced contact with the family five additional times in September 2024, which were also unsuccessful. The caseworker collaborated with ODHS Self-Sufficiency Programs to determine where the family was accessing benefits. With that information they made additional unsuccessful efforts to contact the parents nine times throughout October 2024. There were continued efforts in November 2024, and finally on December 23, 2024, the CPS caseworker initiated an absent parent search for the family. Throughout these efforts, the caseworker reached out to multiple collateral contacts to ascertain the family's whereabouts.

The allegations for threat of harm to the sibling by their father were coded as Unable to Locate. The assessment closed in May 2025 after the listed

unsuccessful efforts. The concerns for the sibling's safety were unable to be evaluated by ODHS.

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 observed the lack of child welfare history in this case, which allowed for discussion regarding the high number of CIRTs which involved parental substance use combined with high-risk sleep practices. The mother in this case regularly chose to share a sleeping surface with the child, and frequently used marijuana prior to bedtime. The allegations of neglect by the mother were coded as founded, as information gathered throughout the CPS assessment indicated that THC use may have impacted her ability to respond to the needs of the child. There were documented efforts to provide safe sleep education to the mother by local medical providers, but it was unclear if those efforts included information about the extreme risk to infants when their caregivers choose to share a sleep surface when they are under the influence. The mother also seemed not to understand the potential impact of THC use when breastfeeding.

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:

Infants dying in high-risk sleep environments is a major public health concern. It is one of the most commonly reviewed circumstances in CIRTs. As a result, there have been numerous efforts to address this recurring systemic gap. From June 2024 to January 2025, 7 out of 21 CIRTs involved high-risk sleep environments combined with concerns of caregiver substance use at the time of the critical incident. In response, there are several recommendations currently in progress.

Current efforts to address this gap include:

- A statewide safe systems analysis to inform quality improvement efforts that enhance ODHS response to young children impacted by caregiver substance use.

- Training for ODHS staff, and
- A statewide scan - in collaboration with community-based organizations and the Safe Sleep Coalition - to assess current efforts to educate parents about safe sleep.

The CIRT identified a statewide scan as particularly relevant to the improvement opportunities in this case. The CIRT supports this recommendation, which has a due date of May 1, 2026, with some strategies implemented even sooner, as feasible

Another effort supported by this CIRT is an exploration of improved messaging for parents. This work is underway through the communications and government relations teams at ODHS and Oregon Health Authority. They are looking into potential strategies for improving messaging to parents of infants, including those who are prenatal, about safe sleep practices and available community supports. These strategies are due by end of May 2025.