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.

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<tr><td>Date of critical incident:

February 20, 2024</td><td colspan="2">Date Department became aware of the fatality:

February 23, 2024</td></tr>
<tr><td>Date Department caused an investigation to be made:

February 20, 2024</td><td colspan="2">Date of child protective services (CPS) assessment disposition:

April 9, 2024</td></tr>
<tr><td>Date CIRT assigned:

February 28, 2024</td><td colspan="2">Date Final Report submitted:

June 7, 2024</td></tr>
<tr><td>Date of CIRT meetings:

March 26, 2024
May 6, 2024</td><td>Number of participants:

15
20</td><td>Members of the public?

No
Yes</td></tr>
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Level 3 - Restricted

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

Date of report:	Allegation(s):	Disposition(s):
February 20, 2024 **Assignment decision:** 24 Hours	Neglect by the mother	Founded

On February 20, 2024, ODHS received a report alleging neglect of 11-year-old child by their mother. The reporter stated the child was found unresponsive at home around 5:16 p.m. The child was said to have been acting normal when they got home from school. The child skipped naptime at school and was somewhat lethargic but was later dancing before they went into their room. The mother was cooking in the kitchen and went to check on the child in their room and found the child unresponsive. A neighbor arrived at the home and performed CPR and the mother promptly called 911. When local law enforcement and Emergency Medical Services (EMS) responded to the home, the child's lips were blue, but their skin was not cold to the touch. EMS administered Narcan, which was not effective. There was no indication the child had asphyxiated on any object or ingested substances, though the mother was known to have a history of substance use. There was methamphetamine paraphernalia found in the home including bags, pipes, and syringes in access to the child. The reporter stated there was also trash, dirty dishes, broken mattresses, and ashtrays/cigarettes in the home. The child was taken to a local hospital and later transferred to a specialized hospital the same night. The child was said to have a genetic condition, which caused tumors all over their body, and the mother had not sought medical treatment, potentially for a couple of years.

The CPS caseworker obtained medical records for the child whose diagnoses included genetic condition and developmental disabilities, presenting with chronic abdominal pain, incontinence, macrocephaly, gross motor and speech delays. Records from the primary clinic the child

attended showed they had never been seen for a well-child check but was only one vaccine behind schedule. The child was last seen at this clinic on August 8, 2022, for head pain. The child was recommended to have annual ophthalmology appointments, which were attended between 2014 and 2016. There was record of one appointment with a pediatric geneticist that was attended in 2018. Additional recommendations from this office included annual monitoring for scoliosis, hypertension and rapid tumor-growth or pain stemming from her condition. No additional follow ups were present in records. The last medical appointment the child attended was on September 14, 2023, at the local hospital emergency room following a motor vehicle accident, where they were observed and discharged with no concerns.

The CPS caseworker had face-to-face contact with the child at the specialized hospital on February 22, 2024. The child was intubated and did not have brain activity. ODHS offered the mother transportation to the specialized hospital, but she declined assistance as she arranged a ride with a relative. The CPS caseworker had unscheduled face-to-face contact with the mother on February 22, 2024. The mother declined an interview but indicated she would speak to the CPS caseworker when she returned home. The child was declared deceased at the hospital at 12:18 p.m. on February 23, 2024, due to anoxic brain injury.

Several reports from local law enforcement were added to the CPS assessment. Officers arrived at the home on February 20, 2024, and began lifesaving efforts until EMS arrived, who continued compressions and administered Narcan with no results. A third-party family friend stated they came into the house to return a dog they were watching for the family, and they observed a neighbor performing compressions. The third-party friend provided rescue breaths to the child.

The neighbor stated they were next door when they heard the mother screaming for help as she ran through the neighbor’s house. He called 911 prior to beginning compressions on the child. The mother told law enforcement that the child had been holding their mouth for the past week, presumably in pain. The mother also stated she believed the child may have had a tumor in their head because they had been holding it over the past few days.

On the night of the critical incident, methamphetamine residue, baggies, and paraphernalia were found in the home within access of the child. Photos taken at the home by law enforcement showed there was a bag labeled Narcan on the floor and several residue baggies within access of the child in the entryway/mudroom. This area was described to be the place where the mother and others would smoke methamphetamine. In the computer area, there was a sharps container within access of the child. The living room had several areas where residue baggies were found on shelves, the coffee table, and the floor. The child's toys were observed on the couch, where the mother stated the child watched Barney before going into their room. In the room where the child and the mother slept, there were several residue baggies found nearby where the child slept and near a bucket where trash was found. When the mother found the child unconscious, they were face-down on the floor with their head near the trash and residue baggies. Initial drug screens at the local hospital were negative for all substances tested. Although these were negative, overdose was not ruled out due to the information about the child seeming happy, dancing, and watching Barney 30 minutes to an hour prior to being found unconscious.

Law enforcement officers spoke with another third-party adult, who was in a relationship with the mother from the time the mother was pregnant with the child until 2019. The third-party adult stated the relationship ended due to the mother resuming use of methamphetamine. The third-party adult continued to maintain a relationship with the child, who would spend the night at their house occasionally and would come visit them at the family home. They had last seen the child a few weeks prior to the critical incident. The third-party adult stated they knew the mother had not been following through with medical appointments since they had broken up, though there was no reason to miss them since the child was signed up for a transportation service. The third-party adult reported they had tried to encourage the mother to take the child to follow-up medical appointments, and that the mother would become upset in response. They stated they didn't have concerns for the home environment but knew the mother was using methamphetamine and allowing other unknown users into the home. When asked about how the mother's substance use impacted her parenting, they said they had no idea because they did not observe her

parenting while under the influence. However, when they would get the child, their hair would be matted, the bottoms of their feet dirty, they would have a diaper rash, and their clothes were too small.

The CPS caseworker spoke with another third-party friend, who frequented the home almost daily for the previous year. They stated they and the mother were methamphetamine users. They stated they only use methamphetamine, though acknowledged there is likely fentanyl mixed in. The third-party adult stated there were around 100 small baggies with residue in the home and paraphernalia. They stated they had multiple conversations with the mother about taking the child to the doctor, and that they had brought this up again on the morning of the critical incident when the child was not feeling well. The third-party adult said the child had diarrhea and vomiting for about a month leading up to the critical incident. They stated the mother did well with the child's day-to-day care and did not report any concerns for abuse.

The CPS caseworker met with the mother on March 5, 2024, after several scheduling attempts. She smelled of alcohol but was coherent. The mother stated she had a drug problem and would smoke meth one time per day either in the shed or the mudroom in the home. The child was sometimes present when she used, and she stated she would always check on them and did not leave the home. She stated she relapsed after the child was abused by a teacher in school (summarized in report dated January 8, 2021), and this was the same time she moved into the home of another third-party adult, who declined an interview with ODHS. The mother stated she believed she was set up by them and the third-party adult who frequented the home the previous year. She stated the third-party adult had cameras in and outside the home and would watch the mother and child on the cameras. The mother believed the child had been poisoned by them and their death was not an accident.

The mother said she had not followed up with regular medical care, annual appointments, or Applied Behavioral Analysis therapy since 2018. She stated the COVID-19 emergency impacted these appointments. In response to the appointments needed after the emergency, she stated she dropped the ball and had options to take the child to these appointments.

The mother's account of events started with the night of February 19, 2024. She stated the child had been up most of the night, was swallowing a lot and the mother thought she would throw up. The mother brought the child a bowl in case of vomiting, which they pushed away. The morning of the critical incident, the child did not seem their normal, happy self but had no fever and did not vomit. The mother told the child they could stay home from school, but the child saw the school bus and wanted to go. Upon returning home, the school bus attendant said the child didn't take a nap that day and it seemed like something was bothering them. The child entered the home and watched Barney on the couch, was giggling and jumping around. The child then seemed sleepy and went to their room, where the mother thought they would take a nap since they did not have one at school. After about an hour, the mother went to wake the child up so they would be able to sleep that night, but upon entering the room, they were on the floor laying on their side. They were not breathing, and the mother dragged them by their feet into the living room and went next door for help. She would not directly answer if she had used methamphetamine the day of the critical incident.

The CPS caseworker communicated with law enforcement about the mother's report of cameras and poisoning of the child. The detective had located the equipment in the home and verified there were only cameras outside. The footage from the cameras on February 20, 2024, did not indicate any crime.

None of the adults interviewed had contact information for the non-legal, alleged biological father. The mother stated they were not in a relationship when the child was conceived and that he has been uninvolved except for seeing the child on their birthday for the first three to four years of their life. He was not located during this CPS assessment.

The allegation of neglect of the child by their mother was coded as founded. Baggies with methamphetamine residue and paraphernalia were within the child's access. The child had high medical and behavioral needs and did not receive recommended follow-up care.

Description of relevant prior Department reports under the mother's case name:

Date of report:	**Allegation(s):**	**Disposition(s):**
April 30, 2015 **Assignment decision:** Alternative Response, 5 days	Neglect by the mother	No Disposition

On April 30, 2015, ODHS received a report alleging neglect of the child, who was 2 years old, by the mother. The reporter stated the child has severe tooth decay and had been examined by a dental provider three times since October 2014. At each of the appointments, the mother was told the child needed a procedure including anesthesia, dental caps, and a root canal. Due to the child's special needs, they needed to be examined by a physician prior to the procedure. The last appointment the child was seen was April 24, 2015. The reporter stated the mother blamed the dentist and staff for not getting the child in for surgery. Staff at the office tried to reach the mother via phone call after this appointment, but she had not returned phone calls or made any appointments for the child.

The CPS caseworker made phone contact with the mother on May 1, 2015, and scheduled face-to-face contact for May 5, 2015. During this contact the child, the mother, and her partner were present. The mother had been in a relationship with her partner for four years and was referred to as the child's other parent.

The mother reported the child had an appointment scheduled for dental surgery on June 4, 2015, and a pre-dental physical appointment for May 19, 2015. The mother had some trouble with Oregon Health Plan (OHP) coverage that she became aware of on November 3, 2014, following the October 2014 dental appointment. She had filled out the initial paperwork and waited six weeks to hear back from OHP. The mother said she had made multiple calls to OHP to resolve the situation and was told she needed to start the process over again. The mother had taken the child back to the

dentist on April 24, 2015, due to the child breaking their front tooth in a fall. The mother did not get confirmation of OHP coverage until recently and had made the appointment right away.

The mother and her partner stated it is difficult to brush the child's teeth because the child has oral sensitivity related to autism, though they try to do so daily. They stated the child did not make any outward signs of pain or discomfort while eating. The child was observed eating cheese puffs during this visit, and the CPS caseworker did not note them to be in any pain while eating.

The CPS caseworker contacted the dental provider the child attended, who confirmed the mother's reports, and that there was an appointment for surgery. The child was involved in early intervention services/early childhood education and the CPS caseworker spoke to an autism specialist and speech pathologist from this agency. Both individuals reported knowledge of the child's dental needs and that the mother had gone through a long process trying to secure OHP coverage for the dental procedure. One of the individuals stated the mother and her partner had been saving to pay out-of-pocket for the child to have white tooth caps instead of silver ones that were covered by OHP. This individual also confirmed the child has significant oral aversions, and this sensitivity makes it very difficult to brush their teeth. Both individuals stated no concerns for the child or the caregivers, and that the mother had followed through on recommendations from their agency.

An absent parent search was conducted for the alleged biological father on May 5, 2015. He was not contacted during the CPS assessment for lack of contact information. The mother stated he had sporadic, infrequent contact with the child.

This was an alternative response report, and no disposition was required. The CPS caseworker articulated there were no active safety threats with the family and there was no need for additional referrals to services.

Date of report:	**Allegation(s):**	**Disposition(s):**
March 28, 2022	Neglect by the mother	Not Applicable

Assignment decision: Closed at Screening		

On March 28, 2022, ODHS received a call of concern alleging neglect of the child, who was 9 years old, by their mother. The reporter stated the child had an in-home therapy session and the child and the mother's whereabouts were unknown. An unknown third-party adult at their home stated the mother may have been arrested, though it was unknown what for or any circumstances. The reporter stated the third-party adult who was there did not want the mother to know they were there. The child was said to have autism, was not verbal or toilet trained, and that they engage in self-injurious behavior. The mother was said to drink alcohol and smoke marijuana though it was unknown if this impacts her parenting. The mother was an advocate for the child, and in the past when she has missed an appointment it was because she didn't have a ride or had the date confused.

The ODHS screener looked at available court records and did not see any arrest record for the mother. There was no indication the mother was not meeting the child's needs, and the report was closed at screening.

Date of report:	**Allegation(s):**	**Disposition(s):**
September 30, 2022 **Assignment decision:** Closed at Screening	Not Applicable	Not Applicable

On September 30, 2022, ODHS received a report regarding the child, who was 10 years old, in the care of their mother. The child was supposed to be picked up from school at 3 p.m. but the mother did not arrive until 6:15 p.m. After several attempts to contact the mother, the school reached out to the mother's former partner who was previously listed as an emergency contact,

however the child could not be released to them. When the mother finally arrived, a CPS caseworker and local law enforcement officer were present. The mother was told they were preparing to place the child into protective custody prior to her arrival. The mother was said to be receptive to supportive service referrals. The reporter stated there were pieces that did not add up about the mother's story of events leading up to being late to pick up the child, and that she did not provide explanation to several questions posed by the CPS caseworker and law enforcement officer. The reporter stated the mother had been late to pick up the child several times in the past.

This report was closed at screening as it did not constitute an allegation of abuse. Another screening report with additional information from this incident was reported on the same date and was assigned for CPS assessment. Additional information can be found below.

Date of report:	**Allegation(s):**	**Disposition(s):**
September 30, 2022 **Assignment decision:** 24 Hours	Neglect	Unfounded

On September 30, 2022, ODHS received a report alleging neglect of the child, who was 10 years old, by their mother. This is a subsequent report related to the mother picking up the child from school late. The reporter stated local law enforcement personnel and a CPS caseworker responded to the situation. The child was said to have pulled out handfuls of their caregiver's hair and hit them because they were so upset about waiting for the mother. They indicated the mother was late to pick up the child several times during this week. The mother stated she struggled with time management and there have been issues lately due to lack of services and supports. The child was impacted by autism and was dependent on the mother for all basic needs. The child could be aggressive toward others and had to be unsupervised around peers. They needed assistance for toileting and was said to have rashes in their private areas. The mother

stated she had traveled out of town selling some items and her car was overheating on the way back, which caused her to be much later than expected.

The CPS caseworker contacted the child, the mother, the mother's former partner and several school collaterals on the evening of September 30, 2022. Collateral contacts at the school indicated the mother is often late to pick up the child from school, but this was the first time she had been so late. The CPS caseworker observed a support staff being hit by the child, and the child had taken out some of their hair. The mother's former partner arrived at the school at 4:50 p.m. to pick up the child. However, since they were not a current emergency contact, the school could not release the child to them. The mother's former partner stated they had gotten a call from the mother, who stated her car was broken down and she had to walk to cell service. They said the mother is a good parent who tries to do everything she can to care for the child. The mother put their former partner back on as an emergency contact during initial contact. The mother stated she and the former partner argue a lot and they were no longer in a relationship. She said there were additional individuals she would add as emergency contacts to avoid this situation reoccurring.

The mother arrived at the school at 5:56 p.m. The CPS caseworker observed the mother's hands were dirty with what appeared to be from the car engine. She stated she had left at 10 a.m. to go to another town to sell bikes. She left that town around 12 p.m., but her friend's car was overheating, and she had to pull over often, and had reached out to her former partner to pick up the child.

The mother said she had gone from having a lot of support to having very little and was struggling with time management as a single parent. The child used to be connected to Disability Services but had lost confidence in getting help from other people as she did not trust people being around the child because they were non-verbal. The child wears diapers and sometimes does not want to be changed and the mother has a hard time changing them. The child would get rashes, but there was never an occasion where they needed medical attention for it. The mother believed the child did not want to be touched, bathe or brush their teeth because they were getting older. The mother stated she has participated in

Alcoholics Anonymous and Narcotics Anonymous in the past. She started using methamphetamine around age 19 and went to treatment in 2009. She denied any current use. The mother accepted referrals for supportive services and Disability Services. The CPS caseworker observed the family home and had no concerns for the environment.

The allegation of neglect to the child by their mother was coded as unfounded and the CPS assessment was closed using the documentation protocol. This was the first time the mother had been this late in picking up the child and the mother attempted to have their former partner pick up the child.

Date of report:	**Allegation(s):**	**Disposition(s):**
March 24, 2023 **Assignment decision:** Closed at Screening	Not Applicable	Not Applicable

On March 24, 2023, ODHS received a call of concern regarding the child, who was 10 years old, in the care of the mother. The reporter stated the mother had a history of picking up the child late from school, and school staff had been instructed to call the non-emergency law enforcement line when they were more than 30 minutes late for pick up. On March 21, 2023, school staff had called the non-emergency line as asked, and an approved emergency contact came to retrieve the child from school. The child had not returned to school since that date, and staff had not been able to reach the mother. The reporter stated the mother had previously confirmed they would be present for the child's IEP meeting on March 23, 2023, but the mother did not appear or respond to any calls. The reporter did not know of any substance use or concerns of violence in the home. The child was very vulnerable and needed constant supervision, though the reporter had no concerns about the mother's ability to meet their physical needs. The child received some medical care at school and the reporter stated some

treatments, such as Applied Behavioral Analysis, would be dropped due to lack of attendance.

The report was closed at screening as it didn't constitute an allegation of abuse.

Date of report: April 4, 2023 **Assignment decision:** Closed at Screening	**Allegation(s):** Not Applicable	**Disposition(s):** Not Applicable

On April 4, 2023, ODHS received a call of concern regarding the child, who was 10 years old, in the care of her mother. The reporter stated the child had not been picked up from school, which released an hour ago. The School Resource Officer went to the family home and there was no response. Typically, the mother or a friend would pick up the child from school, but the mother's whereabouts were unknown. The child was said to be impacted by autism and was non-verbal. There was no additional information documented about whether the child was picked up from school or returned home safely.

This report was closed at screening as it did not include an allegation of abuse.

Description of relevant prior Department reports under a third-party adult's case name:

Date of report: January 8, 2021 **Assignment decision:** 72 Hours	**Allegation(s):** Physical Abuse by the third-party adult Neglect by the third-party adult	**Disposition(s):** Not Applicable

On January 8, 2021, ODHS received a report alleging physical abuse and neglect of the child, who was 8 years old, by a third-party perpetrator. The reporter stated a paraeducator from the child ‘s school informed them they had witnessed the third-party alleged perpetrator, also a paraeducator, pick the child up by the arm and spank them sometime in spring of 2020. The alleged perpetrator justified the action by saying it was the only way to make them listen. This report was assigned to the Office of Training, Investigations & Safety (OTIS) for assessment.

The OTIS investigator interviewed the mother on January 14, 2021. The mother stated the child is enrolled with special education services at their elementary school. The child is impacted by autism, is not potty-trained and is nonverbal. She stated the alleged perpetrator was the assigned one-on-one paraeducator for the child, and that the alleged perpetrator had also provided childcare outside of school hours in her home. The mother heard from another paraeducator at the school this had occurred. She stated the other paraeducator reported this incident to the Special Education Program Manager and Human Resources staff at the elementary school. The mother reported she was also concerned the child returned home from school recently with unexplained scratches and red marks on their face and back. The mother reached out to the child’s teacher who stated the child acts out and resists staff while being changed.

The paraeducator who witnessed this occurrence stated the child had become agitated and upset toward another student who was using a swing that they wanted to play on. The paraeducator and the alleged perpetrator placed themselves between the two youth, and the child continued to be agitated. The alleged perpetrator then grabbed the child by the arm and swatted them a couple of times on the buttock area. The para-educator reported this behavior to the classroom teacher who did not say anything about following up on this concern.

The child’s teacher stated they remembered the other paraeducator coming to them sometime last year but not specifically when. The paraeducator expressed concern that the alleged perpetrator was spending too much time with the child and recommended they change the child’s one-on-one to them. The teacher stated they made the change to the schedule and did

not notify the alleged perpetrator as to why the change was made. The teacher stated they would have immediately reported it to the school principal if they knew the allegations listed in the screening report. The teacher indicated there are behavioral logs for each child in the classroom as well as diaper change logs, which prompted for any marks on the children. Upon review of these, there were several pages of the log missing, but no concerns regarding these allegations were listed there.

The school's principal had only one record of an incident occurring with the child, which was unrelated to these allegations. The alleged perpetrator was placed on administrative leave.

The alleged perpetrator denied ever being alone with the child as paraeducators work in pairs at the school. They stated they were certified in appropriate physical interventions when children are acting dangerously to themselves or others. The alleged perpetrator denied ever abusing a child in the presence of another paraeducator or otherwise. They said this type of work can be stressful, but they had always maintained composure when working with children with high needs. The alleged perpetrator believed the mother was making up allegations to extort money from them since they recently came into some money. The mother never stated any concerns to them about any of the care the child received until now. The alleged perpetrator was offered a polygraph to verify their statements, which they agreed to, but later refused.

The allegations of physical abuse of the child by a third-party perpetrator, were coded as unable to determine. Witnesses described the alleged perpetrator using physical discipline on the child to stop them hyper-focusing on the play equipment. There was no documentation or images of physical markings related to this and there was not enough evidence to support a founded disposition. The allegation of neglect to the child by a third-party perpetrator was coded unable to determine. The evidence did not establish the alleged perpetrator's actions as endangering to the health or welfare of the child.

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:

There were two improvement opportunities identified for Oregon Child Abuse Hotline (ORCAH) screening practice. The initial report from September 30, 2022, met criteria for CPS assessment, but the second assigned report from the same date indicates this was resolved. The report dated April 4, 2022, also met criteria for CPS assessment. There was minimal information provided in the report and in isolation it did not meet criteria for assignment. However, given the mother's pattern of being late to pick up the child from school and the child's high level of vulnerability, additional information could have been gathered to support assignment for CPS assessment.

The CIRT noted the improvement opportunities with ORCAH screening practice in this case are reflective of common practice problems. There are several quality improvement efforts to address gathering sufficient information in reports to ORCAH. Screening consultants are now available to ORCAH screeners and supervisors who work beyond traditional work hours. A full-day training for screeners occurred in March 2024, which focused on the context of family culture and improving practice for understanding family functioning. Screening consultants and supervisors regularly conduct Closed at Screening reviews and live-listening sessions of screening calls for targeted coaching and quality assurance. These efforts are directly related to improvement opportunities in this case, and the CIRT did not identify additional recommendations for improvement.

With acknowledgment that the COVID-19 emergency may have impacted this situation, the CIRT observed the period between 2018 and 2022 where the child did not attend recommended appointments as an opportunity for improvement in community collaboration with ODHS.

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 a representative from Child Fatality Prevention & Review program, the local Community Developmental Disabilities Program, and the local Coordinated Care Organization explore existing processes, and opportunities for increased collaboration when working with families with children who have high needs and are not receiving recommended

care. This exploration and any recommended actions for improvement will be complete by September 30, 2024.